Toronto Central LHIN

Annual Report 2014 – 2015

Ontario
Local Health Integration Network

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1. Message from the Board Chair and the CEO

We are very pleased to present the Toronto Central Local Health Integration Network (LHIN) 2014-2015 Annual Report.

We have made great strides in recent years. We have reached out beyond the traditional borders of health care and forged new partnerships to better address the factors that impact people's health. We have achieved greater sustainability of the system through our active support of the voluntary integration of services. We have created new, innovative tools, and gathered data to help us better understand the unique needs of patients in our communities and to identify gaps in care.

Our focus this past year has been on improving care for high needs populations, improving the patient experience, improving value and efficiency of health care resources and sustaining our gains. The key accomplishments this last year that support these strategic priorities include: connecting key players for more targeted planning, creating new models for service delivery and working with targeted populations to improve services.

We recognize our role in the health care system has evolved since the development of the 2013-2016 Integrated Health Service Plan (IHSP-3) which has guided our work over the last 2 to 3 years. For example, the health system has seen the implementation of transformational initiatives such as Health Links and Health System Funding Reform. To better reflect these changes and how our activities support the priority objectives we have set, in 2014-15, we undertook a strategic planning process to update our strategic plan.

The IHSP-3 created the foundation for the work that will be carried out in the implementation of the Toronto Central LHIN's 2015-18 Strategic Plan. None of the activities of the IHSP-3 are lost in this translation; however, many of the activities that drove the priorities have moved into operations and our core business. This work continues and is critical to our ongoing success.

Our new strategic plan reflects countless hours of reflection, valuable conversations with a broad range of stakeholders and in-depth analysis. We have assessed our successes and failures, developed an ambitious, yet pragmatic vision of what we want the health care system to look like, and crafted a practical strategy to move our goals forward.

Similar to the consultations undertaken to inform the IHSP-3, this strategic update process involved extensive engagement with our local community including health service providers and their boards, consumers of health services and the public, and in

particular, marginalized populations that are not traditionally heard in health system planning and design.

We recognize there is still much more work to do to ensure our system reflects the needs and realities of all those who live in or access care in the Toronto Central LHIN. More can be done to make our system less fragmented and confusing, and to provide timely access to quality care. Perhaps most importantly we need to take our investments in the health care system to build solutions that focus on long-term system sustainability.

It will require a firm commitment and a collective effort to move beyond best intentions and to ensure we deliver timely results. Ultimately, our new strategic plan will help us better serve Ontarians as a mission-driven, high impact, health management organization.

Angela Ferrante
Board Chair

Camille Orridge
CEO

2. Toronto Central LHIN Profile

Overview by Sector

The Toronto Central (TC) LHIN has the highest concentration of health services in Canada, with 172 unique health service providers, which offer 202 unique programs and services.

- 17 hospitals with a total of 2,163,008 inpatient days (2013/14 YE).
- 17 community health centres (CHCs) providing an estimated 449,759 face-to-face encounters (2013/14 YE).
- 61 agencies providing community support services (CSS) totaling an estimated 1,128,079 community visits and 924,799 resident days (2013/14 YE).
- 70 agencies that provide community mental health and addictions (CMHA) and problem gambling services totaling an estimated 1,409,503 visits (2013/14 YE).
- 1 Community Care Access Centre (CCAC) providing an estimated 164,124 visits for case management services (2013/14 YE).
- 36 long-term care (LTC) homes accounting for almost 6,723 approved LTC beds (equivalent to 2,453,235 bed days available for admission) (2013/14 YE).

TC LHIN Population Facts

- Toronto's downtown core is growing at four times the rate of the rest of the City of Toronto[1].
- The fastest-growing age group in the City is seniors[2] and this group is expected to make up 22.6% of Toronto's population by 2041[3].
- Toronto remains a multicultural hub with the highest percentage of immigrants in Canada[4]. One-third of Toronto's immigrants arrived in Canada within the last 10 years[5].
- 140 languages and dialects are spoken in Toronto[6].
- Approximately 5,000 people are homeless in the City of Toronto[7].
- Toronto has the largest community of lesbian, gay, bisexual and transgender people in Canada.

- In Toronto, 26% of the population is living in poverty[8]. Income is considered the most significant contributor of the social determinants of health.

- Over 60% of the care provided in TC LHIN is for patients outside our catchment area. Our health care system plays a local role as well as a regional and provincial one. In addition to the people who reside in the TC LHIN area, health service providers in the LHIN also serve people from across the Greater Toronto Area (GTA) and Ontario. A number of hospitals in the TC LHIN provide tertiary and specialized services that are not offered anywhere else in Ontario. Also, a large number of daily commuters come into Toronto each day, some of whom receive primary and other health care services in the TC LHIN.

Select Populations in the TC LHIN

TC LHIN has worked to identify key populations and more specifically, the challenges that certain populations experience in accessing or benefiting from services. These challenges result in gaps in health outcomes relative to the rest of the population. Recognizing that demographics provide significant insight into the current and future health care needs of a community, the LHIN has been working to ensure that its planning and implementation activities are reflective of both the local demographics, as well as the broader demographic drivers affecting access to care and care delivery.

An Aging Population

In TC LHIN, those aged 65 years and older account for 13.1% of the population.

Seniors are living longer than ever before and while this is testament to the successes of modern medicine, it also brings with it tremendous social and economic pressures. Health care use rises as people age and most costs are incurred during people's final years of life. With the large cohort of aging baby boomers reaching their senior years, health care costs will inevitably continue to grow. Our challenge is to manage the rate at which those costs grow by improving the quality and efficiency of care and investing in services that add value.

Aboriginal Peoples

Toronto's Aboriginal population accounts for between 25-30% of the overall population of First Nations and Aboriginal people in the province. Toronto's diverse Aboriginal community is comprised of many different Indigenous peoples from across the country. This is a very mobile community. Aboriginal people will migrate from their home community to Toronto for their health care needs. For example, where care is not available or optimal in northern communities, residents will travel to the City to assess services and then return back to their home community. Aboriginal people also move to urban centres for better access to housing and education.

Aboriginal communities have significant health disparities when compared to other populations, and have long been marginalized within the mainstream health system due to systemic discrimination and racism[9]. There is limited information about the health status and service utilization patterns of Aboriginal people as there is

currently no way to extract this information from current data sets.

The Aboriginal population is growing at a faster rate than the non-Aboriginal population[10]. In Toronto, agencies serving the Aboriginal community estimate that there are between 70,000-80,000 people in the City who identify as Aboriginal. This estimate has been in use since 2006. Historically, Census figures puts this number much lower however Census data reflects only those persons living in private households. Individuals who lived in collective residences, institutions or who were homeless or under-housed at the time of the enumeration are not reflected. According to the 2011 Census, there were 36,995 Aboriginal people living in the GTA.

Francophones

In Toronto, Francophones do not tend to live in any particular neighbourhood. French language health services are also scattered across the TC LHIN making it difficult for people to navigate services.

- Toronto has a Francophone population of 59,000, many of whom are recent immigrants and/or visible minorities[11]. Almost half were born outside of Canada.

Immigrants

Newcomers often encounter barriers to care, particularly if they do not speak English. Evidence shows that people with limited proficiency in English tend to stay longer in hospital as do those who are unable to communicate with care providers in their first language.

- 8% of immigrants in Toronto arrived in Canada between 2006 and 2011[4].
- Toronto is home to 52.6% of all immigrants living in the GTA and 36% of all immigrants living in Ontario[4].
- 5% of Toronto's population reports no knowledge of either official language[4].

Refugees

There were 6,490 refugee claimants in calendar year 2012 for the City of Toronto[12].

The top 5 countries of citizenship for refugee claimants are: People's Republic of China, Iraq, Sri Lanka, Afghanistan and Haiti[12]. Refugees need access to care for general health care as well as any conditions they have as a result of their particular experience. There is widespread concern that the federal government's change to the Interim Federal Health Program, a program that provides temporary health benefits to refugees, is potentially very harmful to a vulnerable population group.

People Affected by Mental Health and Addictions Issues

Mental health and addictions affects a considerable proportion of people in TC LHIN who require ongoing treatment and supports. The prevalence is much higher among the top high cost users and varies by Health Link. In 2012/13, 80,759 (8.4%) adults 20 years and older had mental health visits to physicians. This is an underestimate as it does not include non-Ontario Health Insurance Plan (OHIP) claims or those people with mental health and addictions who do not see physicians.

TC LHIN reported 42,549 mental health and substance abuse–related visits to the Emergency Department which accounted for approximately 4.1% of all Emergency

Department visits (FY 2013/14). The average length of stay in a TC LHIN hospitals for mental health/substance abuse patients was 38.1 days (FY 2013/14). Repeat visits to the Emergency Department for mental health and substance use are high for TC LHIN hospitals, the most recent data available (FY 2014/15, Q3) indicates a rate of 27.9% for mental health and 41.7% for substance use.

2014/15: TC LHIN in Motion

Over the last four years, TC LHIN worked to develop key infrastructure that allows us to collect information to identify the health care system's most complex patients. Our intent is that this data will allow us to target strategies through our Health Links Networks to better manage these patients. These efforts were strengthened by focusing on programs that mapped availability of services (location, intensity and access) to need. Through this work, it has become evident that specific strategies for the many sub-populations (e.g. stroke patients, refugees, Francophones, Aboriginals, etc.) are required, in part to leverage services that already exist and also to address unique gaps that drive demand on the more acute end of the health care spectrum.

2014/15 represents the second year of TC LHIN's 3-year Integrated Health Service Plan (IHSP-3). The IHSP-3 builds on the directions set out in Ontario's Action Plan for Health Care and supports major provincial directions, such as Health Links. The IHSP-3 identifies the following Strategic Aim and Priorities:

Strategic Aim:

Transform the system to achieve better health outcomes for people now and in the future.

The five IHSP-3 Strategic Priorities address the most urgent local health needs and offer the greatest opportunity for system change to meet our goals for patients.

1. *Address the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources.*
2. *Prevent and delay serious illness and injury among those who are at greatest risk of declining health.*
3. *Improve the patient experience.*
4. *Deliver value and sustainability through efficient use of resources.*
5. *Sustain our gains.*

The work of the LHIN can be split between core functions– which represent to the work of managing system performance; and a number of strategic areas of focus that revolve around planning for the future, investing in tests of change, and supporting innovation in health care delivery.

The LHIN's core functions are those lines of business that were our first responsibilities when the LHINs were established. This work is best described as the basic management of the health care system – funding, performance management and integration.

The two key drivers for successful management of the system are: the development of mature relationships with our health service providers and a robust and rigorous measurement and performance reporting structure.

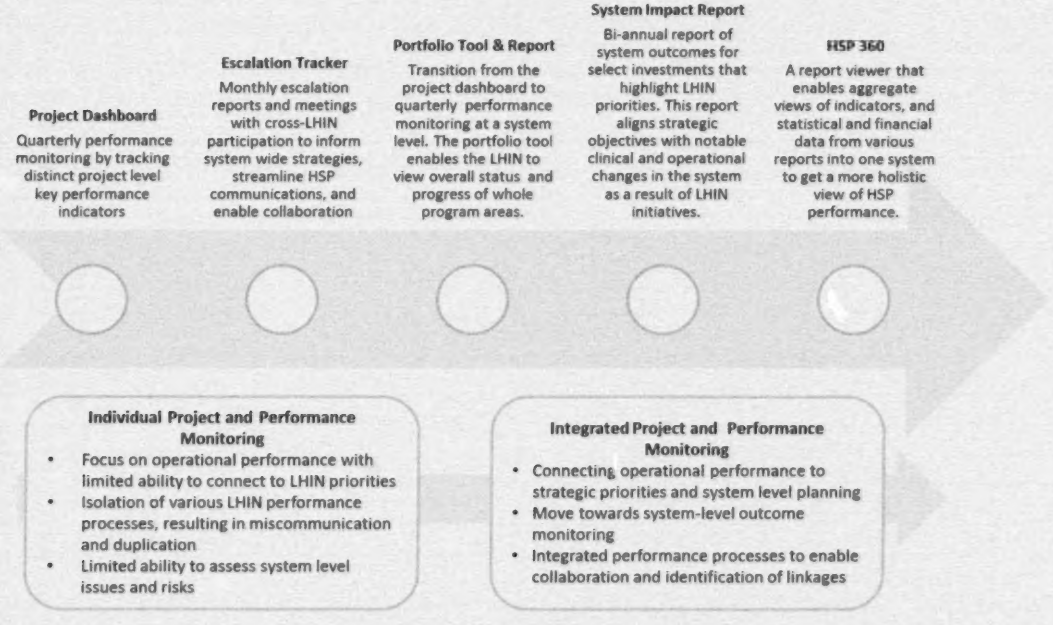
Effective Relationships to Manage to Fiscal Requirements

We have 172 health service providers with established accountability agreements, and these agreements govern $4.7 B in investments. Our expectations of our health service providers are clearly laid out, both through our formal accountability agreements and through our relationships at all levels between organizations – from analyst to CEO. We have established a culture of proactive management when it comes to budget shortages, operational pressures and patient care issues. Regular and open communication between the LHIN and health service providers has created relationships that are highly cooperative and forged on clear accountability, ensuring that we receive early signals of problems, allowing us the time for joint development of solutions. This approach allows us to ensure that patient care is not jeopardized.

This year marks the fifth year of continuous fiscal restraint with growth in service budgets below the cost of living increases and zero percent growth in the hospital sector. Despite the challenges this presents, all of our health service providers were able to achieve a balanced budget. This was made possible through careful monitoring and management of issues as they arose.

Performance Measurement and Evaluation

Clear expectations of health service providers are reinforced by robust performance measurement objectives. Performance measurement and evaluation is a body of work that we have built over the last four years and our capacity has grown dramatically. The evolution of performance measurement at the LHIN shows the maturity of our relationships with providers and is still advancing as we continue to work with our health service providers and other partners. The illustration below demonstrates the evolution of our approach to performance measurement and evaluation.


Project Dashboard
Quarterly performance monitoring by tracking distinct project level key performance indicators
Escalation Tracker
Monthly escalation reports and meetings with cross-LHIN participation to inform system wide strategies, streamline HSP communications, and enable collaboration
Portfolio Tool & Report
Transition from the project dashboard to quarterly performance monitoring at a system level. The portfolio tool enables the LHIN to view overall status and progress of whole program areas.
System Impact Report
Bi-annual report of system outcomes for select investments that highlight LHIN priorities. This report aligns strategic objectives with notable clinical and operational changes in the system as a result of LHIN initiatives.
HSP 360
A report viewer that enables aggregate views of indicators, and statistical and financial data from various reports into one system to get a more holistic view of HSP performance.
Individual Project and Performance Monitoring
• Focus on operational performance with limited ability to connect to LHIN priorities
• Isolation of various LHIN performance processes, resulting in miscommunication and duplication
• Limited ability to assess system level issues and risks
Integrated Project and Performance Monitoring
• Connecting operational performance to strategic priorities and system level planning
• Move towards system-level outcome monitoring
• Integrated performance processes to enable collaboration and identification of linkages

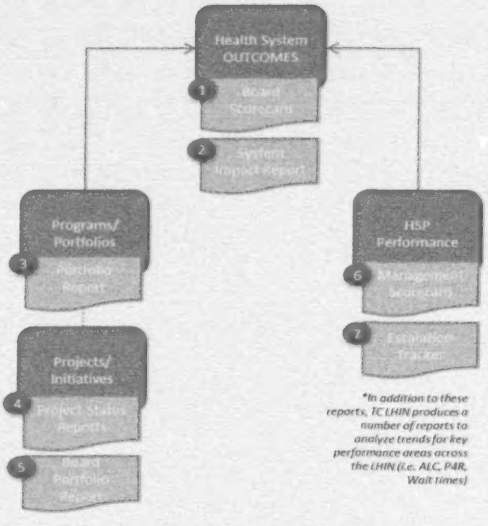
We have built systems that allow us to monitor indicators and other data points that demonstrate how the system is functioning. For example, we can view the Ministry LHIN Performance Agreement indicators on a monthly basis. This has moved us away from isolated measures of individual projects and siloes of operational performance, to a clearer indication of how our work and decisions impact the system as a whole.

The culmination of the work to date on performance measurement and evaluation has resulted in greater integration of our reporting mechanisms with a focus on delivering measurable results. Knowing that transparency of performance information is one of the greatest drivers of individual performance, we are taking steps to promote transparency and accountability for performance among health service providers.

In 2014-15, TC LHIN delivered HSP360. This reporting system aggregates all data and information reported by our health service providers and provides a consolidated view of performance. The system allows for benchmarking and cross-sectorial comparisons. This level of transparency will transform accountability from being largely LHIN-driven, to one that will be strengthened by health service providers holding one another accountable given the level of inter-dependencies in the system.

Summary of Key Reporting Tools Developed by TC LHIN

Performance Monitoring Reports	Frequency
1. Board Scorecard Provides a summary of current MLPA indicator trends. It supports discussions regarding the impact of HSP level performance on overall LHIN performance and provides trending over a period of time.	Quarterly
2. System Impact Report Provides system outcomes for select investments that highlight LHIN priorities. This report aligns strategic objectives with notable clinical and operational changes in the system as a result of LHIN initiatives.	Bi-annual
3. Portfolio Report Provides a comprehensive overview of all LHIN activity by program area. It identifies program level progress, and risks and issues as well as individual project status.	Quarterly
4. Project Status Reports Project partners submit quarterly status report templates that help the LHIN monitor project financials, milestones and deliverables, and timelines.	Quarterly
5. Board Portfolio Report Provides updates on projects and program areas which have had significant activity within a given quarter.	Quarterly
6. Management Scorecard Provides MLPA indicators and information to assess trends in key performance areas. It is intended to support analysis into areas that the LHIN is under-performing, sustaining performance, and performing above average.	Monthly
7. Escalation Tracker Provides detailed information regarding the number and type of escalations in the LHIN by HSP, program and project. A cross-LHIN monthly meeting is used to determine linkages and contributing factors for underperformance and determine any further action required.	Monthly


Health System OUTCOMES
1 Board Scorecard
2 System Impact Report
Programs/ Portfolios
3 Portfolio Report
HSP Performance
6 Management Scorecard
7 Escalation Tracker
Projects/ Initiatives
4 Project Status Reports
5 Board Portfolio Report
*In addition to these reports, TC LHIN produces a number of reports to analyze trends for key performance areas across the LHIN (i.e. ALC, P4R, Wait times)
The portfolio tool facilitates the collection of project information and data that is used to inform the reports above.
HSP 360 supports HSP performance monitoring by aggregating disparate HSP reports into one system to inform HSP performance reports.

3. Strategic Areas of Focus to Transform the System

It is only through sustained efforts to build infrastructure, knit together existing resources and the spread of innovation across the LHIN and beyond our borders that we will achieve a high performing sustainable system of care.

This year, we highlight three areas of work with examples to illustrate how the LHIN executes its role in system transformation:

- Connecting with Key Players for Planning
- Creating New Models for Service Delivery
- Working with Targeted Populations to Improve Services

Connecting with Key Players for Planning

I. Joint Planning with the City of Toronto

TC LHIN recognizes that in order to improve health and health outcomes, we must partner with those who have a direct and significant relationship to the social determinants of health. We also appreciate the importance of engaging other sectors (e.g., training and education) to help us meet future demands, particularly in relation to health human resources (enough people with the appropriate training). We have various planning tables and committees that help us expand our reach to better service the diverse needs of Toronto's residents.

TC LHIN has partnered for example, with various departments of the City of Toronto to strengthen our planning linkages and to better coordinate our shared work and responsibilities. This work is supported by the GTA and Five LHINs Planning Table. This leadership table is co-chaired by TC LHIN and the City of Toronto and consists of senior leaders from the City of Toronto and the five LHINs located in the GTA: Central East, Central, Central West, Mississauga Halton and TC LHINs.

The purpose of the planning table is to identify health and social welfare issues that jointly impact the City and the five LHINs. The planning table meets twice annually to discuss and agree upon the joint systemic issues to be addressed by the group. Once issues are identified, joint working groups are convened to develop action plans and carry out the work.

Example: Shelter Population

The City of Toronto and the Five GTA LHINs Planning Table established a working group to develop discharge options for homeless clients requiring health care services post an acute care stay. Typically, these clients end up in shelters. The issue is that shelters are not designed to support the delivery of health care services.

The Health Care in Shelters working group will determine the profile of the clients in shelters with the most complex health care needs. This group will also develop discharge options for homeless clients with health care needs leaving a hospital as well as for those leaving a shelter.

This year marked a significant shift in the LHIN's relationship with the City of Toronto. This new partnership and approach to planning has produced a number of other benefits. For example:

- Developed a consistent approach amongst the five LHINs and the City to address issues of mutual concern. We now have a system in place to tackle shared problems that reduces inefficiencies and facilitates the pooling of resources and expertise.

- Created a high-quality, standardized web-based data set. In partnership with the Toronto Community Health Profiles Partnership, the TC LHIN has developed a comprehensive data set that ensures timely, relevant and accessible health-related data that is available at various levels of geography for the LHIN and its health service providers. Access to appropriate data and indicators allows us to plan more effectively for neighbourhoods. Data points include:

    - Socio-demographic characteristics of neighbourhoods in Toronto
    - Health service utilization
    - Health outcomes
    - Health equity measures

- Currently working to align health planning with the Municipal Growth Plan. Planning for community capital or physical space is currently not connected to the growth plan in cities. This presents a significant challenge for the TC LHIN because intensification of the downtown core dramatically impacts health care services. The downtown core (defined by Bathurst St., Davenport Rd., Don Valley Parkway and Lake Ontario) has seen huge growth over the past several years and it is far out-pacing other parts of the GTA. For example:

    - From 2006-2011, the population grew by 18%.
    - 71,000 condo units were constructed between 1971 and 2011.
    - Approximately 75,000 additional units are under construction, are approved, or are under review by City Planning. If built, these units will double the population in the downtown core.

There is a clear recognition for a stronger bilateral relationship between the City and the LHIN and this has been marked by informal ongoing dialogue with the Office of the City Planner throughout the year.

II. Funders Table

In the past, some communities and groups of people have experienced issues around access to appropriate health services and poor health outcomes. The LHIN has identified specific groups that require different supports and proactively partners with others to better serve their health needs. Both the City of Toronto and the United Way, for example, provide substantial supports and resources to communities to address their social determinants of health.

In an effort to improve access and health outcomes for specific groups and communities, the LHIN has established a strategic alliance with its funding partners at the City of Toronto and the United Way of Toronto. The Funders Table will look at opportunities for funding collaborations and streamlining efforts to avoid duplication. This involves for example, selecting specific neighborhoods for targeted focus in order to reach a critical mass of investments from all three funders to drive change.

The Funding Table has prioritized diabetes prevention and management as a first area of focus for the Ministry of Health and Long-term Care (Ministry), LHIN, and Toronto Public Health. As a first step, an inventory of funded agencies and initiatives is being developed. A work plan will be drafted in early 2015-16. This work benefits both the citizens and the health system. Recipients will be able to access comprehensive, integrated services that are designed to reflect their unique needs and neighborhoods. The health system benefits by reducing waste and redundancy.

III. Primary Care Health Human Resource (HHR) Planning Committee

This committee will help inform provincial planning efforts to address the issue of imminent primary care physician retirements and the continuity of care required by current patients. The provincial planning group is responsible for identifying actionable strategies to be implemented in both the short- and long-term to address the issue at hand.

IV. Strategic Advisory Council

Established in 2012, this Council is comprised of a number of organizations and public sectors outside of health given that 75% of health status is influenced by factors outside of the health care system. The main purpose of the Council is to bring a broad range of perspectives together to discuss issues that impact the health of the population and advise the LHIN on matters of strategic importance to improvements in population health.

In 2014-15, the Council focused on three priorities: transitional aged youth; healthy seniors; and, healthy cities. Two Whitepapers were drafted to further the Council's work. One paper studied the impact of the recession on the community sector's fundraising abilities as community organizations often rely on fundraising dollars to provide essential services, such as Meals on Wheels. A second paper focused on housing and health outcomes for complex and at risk populations.

Creating New Models for Service Delivery

Creating new models of care by changing the way that services are delivered is a critical aspect of system transformation because they create efficiencies in the system, while at the same time maintaining or improving quality of care. Re-designing care processes are also a priority because we have heard from patients and their families that the system can sometimes be frustrating, inefficient, and fragmented. Additional key drivers for service changes include funding reform and poor outcomes for a specific clinical group.

We know we can do better. With patients and families in mind, we are bridging gaps in service and expanding capacity where necessary. To change how services are delivered however is no small feat. We are fortunate to work with a group of dedicated health service providers who are committed to improving the system and the health of patients and communities. We rely heavily on our strong relationships with partners to make change happen. Some of these changes involve only one health service provider; in other cases we are dramatically redesigning the whole service delivery process from beginning to end. Redesigning the service pathway may include changing

who delivers the service, how much of it and what type of service.

I. Clinical Effectiveness/Clinical Utilization Committee and Projects

Local implementation of the funding reforms introduced by the provincial government has created the optimum conditions to implement changes in service delivery. Aligning funding incentives with the desired health system outcomes has helped to create buy-in for change that is critical, given that the reforms will result in the movement of patient volumes and funding between hospital partners. From the beginning, the TC LHIN has emphasized shared ownership of the changes, ensuring that all health service providers feel accountable to their sector partners and to the process that was jointly created at the partnership tables.

This work is overseen by the Clinical Effectiveness/Clinical Utilization Committee, which convenes to prioritize project work and to broker consensus on process, change management and how success will be measured with the development of new models of care. TC LHIN and its health service providers then work together to implement service changes, both at the organizational and clinical levels. In our experience, this approach has proven to be inclusive, transparent and effective. In fact, this process has been very successful at aligning health service provider leadership with the government's vision for funding reform.

Twelve projects fall under this area of work:

- Stroke, Total Joint and Hip Fracture Best Practice Implementation - Phase III
- Congestive Heart Failure (CHF) - Phase III
- Academic Health Sciences Centre - Cardiac Care Plan Phase I
- Integrated Orthopedic capacity Plan Phase I
- Community Based Rehabilitation Capacity Plan
- Vision Care Planning - Phase I
- Physiotherapy Reform and Exercise and Falls Prevention Phase II
- Assess and Restore Plan Phase I
- Implementation of Physiotherapy in Primary Care
- Provincial Interest Program (PIP) Reviews - Acquired Brain Injury (ABI) and Stroke
- Provincial Interest Program - Forensic Mental Health (FMH) Provincial Plan Phase I
- Long Term Care Specialized capacity Planning - Rekai Centre

II. Addictions and Mental Health Centralized Access

Many of the clients with mental health, addictions and complex physical health issues experience significant challenges in accessing the services they need. The greater and more diverse a person's needs, the more intersections between and within systems and services. TC LHIN aims to build a more integrated system where those with the greatest and most complex needs will have improved access to the services they need, when and where they need them. The Integrated Service Coordination Model is an illustration of the activities we have undertaken to work toward achieving our aim.

Integrated Service Coordination Model

New funding models for complex mental health clients will require both integration of services and a model of payment that reflects the typical utilization pattern for mental health clients. Their access to services cannot be characterized as an episode, rather it should be captured as a period of time during which the patient's need for services may vary in frequency and intensity.

The Integrated Service Coordination Model will focus on delivering services to complex clients with urgent needs. This model looks to provide team based care through integrated case management and assertive community treatment teams. A key consideration with this model is that the care delivered is flexible and the level of service can increase and decrease depending on client need. Additional criteria include:

- Service coordination roles within the team will have accountability to ensure appropriate and timely services are delivered to meet client needs
- Timely access to service to ensure the client is connected to service immediately upon referral
- Ability to support client-specific crisis plans, and provide timely crisis response
- Integrated partnership with clear roles, responsibilities and accountabilities

TC LHIN invested in two new service models that integrate a continuum of services intended to meet the needs of highly complex clients. Theses integrated multi-disciplinary teams were developed in the Mid-East and South Toronto Health Links. While the aims are the same for both teams, two slightly different models are being tested and evaluated.

Through this work, a number of resources have been developed such as integrated multi-disciplinary support teams, family and peer programs, and building-based teams dedicated to high risk social housing buildings. Additionally, regional resources that provide specialized supports to this population have been incorporated and are ava able to the Health Links – high support housing and respite, transitional Aboriginal youth housing, and culturally adapted behavioural and therapeutic treatments.

III. Housing – Integrated and coordinated service delivery

The link between housing and health is well-established and documented. TC LHIN is home to a number of sub-populations who experience a heavy burden of housing insecurity and related poorer health. People living with mental illness and addictions, for example, are disproportionally affected by the intersection of housing and health. The Centre for Addiction and Mental Health (CAMH) has struggled with high numbers of patients waiting for long periods of time for supportive housing.

When integrated with health services, housing can support the conditions necessary for tenants to receive needed health care services and treatment, pursue their recovery goals and improve their quality of life. The barriers to quality, affordable and appropriate housing in Toronto include a lack of housing capacity, insufficient rent supplements, and poor system and service coordination. TC LHIN is committed to working in partnership with key players including Toronto Community Housing Corporation, community mental

health, addictions, primary care, and other health service providers to remove these barriers and work towards a more integrated, supportive housing model. Through these new and novel partnerships, TC LHIN has experienced success with targeted initiatives that integrate housing capacity with specialized support services.

- With no new rent supplements available, TC LHIN health service providers have found creative ways to leverage existing rent supplements and landlord relationships. Coupled with new TC LHIN service funding, these innovative approaches have allowed for increased capacity in both high and medium supportive housing. For example, people who were doing very well in high support housing were able to move to a program with lower supports, thereby aligning the level of service to the level of need and creating high support capacity. Service coordination took root and transitional supports were put in place to bridge the transition from hospital to home. These combined efforts have resulted in the transition of more than 80 long stay alternate level of care patients from CAMH back into the community where they have successfully maintained their housing, continued to improve their health, and re-engaged in the broader community.

- Recent pilot partnerships between TC LHIN and Toronto Community Housing Corporation point to the potential of integrated and coordinated service delivery for residents at risk. The projects support a 'building' and neighbourhoods based approach and are designed around the needs of the local tenants and community. TC LHIN funds community mental health and addictions services and co-leads, with Toronto Community Housing Corporation, an integration of the health services with other important local services such as primary care, settlement, homelessness services, drop-ins, schools, etc. The pilot projects, which have been expanded in 2014-15, saw significant positive impact on attachment to primary care, mental health and other services and a reduction in disruptive behaviours as well as a reduction in evictions for vulnerable tenants.

Looking ahead, TC LHIN will continue to seek out and build strategic partnerships that leverage the potential of supportive housing to improve health outcomes for Toronto's most vulnerable populations.

Working with Targeted Populations to Improve Services

Although our goal is to improve the health of everyone, we recognize that the path to getting there will be different for individual communities throughout the City. Whether characterized by income, social, racial or ethnic factors, many communities get less benefit from the health care system than others. These differences often reflect disparities in access or other barriers to care. We have been working to better understand the unique needs of select populations and drive the development of targeted solutions that will improve health equity across these groups. We want to ensure that our work benefits everyone and this requires tailored approaches for some groups and communities. The following key

initiatives highlight how the LHIN is working with targeted populations to improve care.

I. Toronto Indigenous Health Advisory Circle

TC LHIN in collaboration with Toronto Public Health and Anishnawbe Health Toronto has launched the Toronto Indigenous Health Advisory Circle. The circle includes 8 members from the urban Indigenous community, each bringing a diverse set of skills and community expertise to the role. There is representation from a balance of youth, elder, men, women and 2 spirited. Membership is also reflective of the diversity of perspectives from Indigenous communities across the province. The circle was launched after extensive stakeholder consultations in January 2015.

Building on the strength and resiliency of Toronto's Indigenous population, the advisory circle will develop the City's first Indigenous Health Strategy with the goal of improving the health outcomes for our local Indigenous population. The circle will work to decrease the widening health disparity gap between Indigenous and non-Indigenous populations, including the social determinants of health.

II. Neighborhood Planning

Together with the Ministry, TC LHIN is developing a multi-year plan to address the needs of residents living in neighbourhoods that require additional primary health care resources. The LHIN has identified six priority neighbourhoods:

- Regent Park/Sherbourne
- Oakwood/Vaughan
- Thorncliffe Park
- Mavety
- St. James Town
- Mount Dennis

The LHIN's focus on priority neighbourhoods is linked to the larger goal of providing a comprehensive basket of services, including family medicine, to these communities in order to help reduce inappropriate Emergency Department visits, to improve chronic disease management and to address gaps in services that contribute to poor health outcomes. Below we highlight some of the work currently underway in select priority neighbourhoods.

Regent Park/Sherbourne

The Ministry recently approved a primary care expansion in Regent Park to be provided through St. Michael's Hospital Family Health Team. The official opening will be held this summer and they have pre-enrolled 800 patients. The Sherbourne Health Centre is slated to be the next site to be developed in line with the LHIN's Enhanced Community Space (Hub) vision.

Oakwood/Vaughan

TC LHIN, in partnership with University Health Network, submitted a proposal for a Family Health Team to be located in the Oakwood/Vaughan neighbourhood. It is anticipated that the Family Health Team expansion will be implemented this year and the LHIN has identified a potential site to host both these primary care services and additional community support services and negotiations are currently under way. TC LHIN is currently engaging with the community to better understand the local needs of residents.

Thorncliffe Park

In December 2014, TC LHIN received a proposal for *Creating a Primary Health Care Home in the Community* report. One identified gap in service was the need for maternal care pre- and post-pregnancy. TC LHIN submitted the report to the Ministry for consideration in January 2015 and the Thorncliffe Park Pregnancy Clinic was officially launched in February 2015.

Flemingdon Community Health Centre, South Toronto Family Health Team, the LHIN and the Ministry continue to work together to increase access to primary health care for this community.

4. Community Transformation

TC LHIN encourages and supports voluntary integration among health service providers. The impact of voluntary integrations can be seen in three areas:

1. client/patient
2. service quality
3. broader health care system

The role of TC LHIN in voluntary integrations is one of oversight to ensure that business cases presented by health service providers pursuing voluntary integration are compelling, comprehensive, meet the legislative requirements, and are consistent with the TC LHIN's Strategic Plan.

Voluntary Integrations – Community and Hospital

Integrations have the most direct impact on the client/patient as exemplified through increased volumes of service, enhanced access to services and improved client satisfaction with services. They also improve the quality of the service, or the way services are provided. The benefit to the system as a whole is seen when health service providers start to identify impacts they can have on other health service providers in other sectors.

In 2014-15 the TC LHIN supported six community voluntary integrations in addition to one hospital voluntary integration. The table below shows the integrations that took place in 2014-15 along with the range of expected improvements and enhancements for each of these integrations. The expected results are our indicators of success for the voluntary integrations. The timeline for voluntary integrations to reach their targets is typically 24 months. These organizations are currently operating within their post integration period and TC LHIN continues to monitor progress towards the achievement of integration objectives and targets every six months.

All the completed voluntary integrations to-date has produced process efficiencies within the integrated organizations resulting in savings in ongoing operating costs. The projected savings in the community integrations are $1,035,973, and for hospital integrations are $8,800,000. All these projected savings are being reinvested in services for clients and patients on a perpetual basis.

TC LHIN has recognized that community health service providers do not have the infrastructure to invest time and resources on integration activity while trying to maintain direct service delivery to clients. In response, the LHIN provides one-time funding to assist with these one-time costs.

The total one-time funding provided to date by TC LHIN is $1,411,985. The key is to ensure that with TC LHIN's investment of one-time funding clients and patients receive an ongoing benefit through enhanced services year after year.

2014-15 Community Voluntary Integrations

Health Service Providers	Integration Objectives	Target	Investment	Timeline
ABI Possibilities and PACE Independent Living	**Increased Service Volumes:** • Day Program Services • Psychology Services	**30%** increase in volumes	**$24,000**	**June 2016**
True Davidson Meals on Wheels and Neighbourhood Link	**Increased Service Volumes:** • Meals on Wheels	**4%** increase in volumes	**$20,973**	**May 2016**
Neighbourhood Link and Central Neighbourhood House	**Increased Service Volumes:** • Congregate Dining • Respite Services • Crisis Intervention • Conversation Circles • Meals on Wheels **Creation of Knowledge Centre for above services.**	**6% to 20%** increase in volumes	**$140,000**	**July 2016**
Three Trilliums and Red Cross Society	**Improve Client Satisfaction Rate** **Develop volunteer opportunities through innovative practices.** **Strengthen "Independent Living" philosophy throughout Red Cross**	**5%** increase Additional **40** volunteers Ongoing	**$105,000**	**June 2016**
Community Outreach Program in Addiction (COPA) and Reconnect Mental Health Services	**Increase Case Management volumes** **Improve Client Satisfaction rates** **Reduce number of avoidable client hospitalizations**	**5%** increase in volumes **New Quality of Life tool.** **5%** reduction in hospital visits	**$150,000**	**October 2016**

Health Service Providers	Integration Objectives	Target	Investment	Timeline
Community Resource Connections and Fred Victor Centre	**Increase Service Volume for Case Management.** **Increase number of clients with combined case management and housing support services** **Set target for high risk clients receiving case management within 24 hours of assessment.**	**20%** increase in volume **30%** increase in volume **100%** of high risk clients.	**$163,000**	**April 2017**

2014-15 Hospital Voluntary Integration

Health Service Providers	Integration Objectives	Target	Investment	Timeline
Bridgepoint Health and Mount Sinai	**Evaluation framework still under development.**	**To Be Determined**	**$1,500,000**	**November 2016**

5. Integrated Health Service Plan Priority Updates

Toronto Central LHIN
2013-2016 Integrated Health Services Plan
OUR VISION To make Ontario the healthiest place in North America to grow up and grow old.
Our Guiding Principles
WHAT WE ARE TRYING TO ACHIEVE
Patient-Centred
Patients, clients & caregivers play a central role in health care decisions.
Community-based
Services delivered close to home when appropriate, balancing local access with the need to ensure quality care & value for money.
Quality
Equitable access for all to safe, appropriate, evidence-informed health care services.
Sustainability
We must sustain our publicly funded health care system for the future.
HOW WE WILL ACHIEVE OUR GOALS
Needs-based
Health care resources allocated based on an understanding of people's needs.
Accountability
We are accountable for ensuring value for the resources that have been entrusted to us.
Leadership
We will lead the change we want to see in the health care system.
Integration
Integration is a tool that supports quality health care & sustainability.
Our Goals
Better Health Outcomes for People Through Equitable Access to Quality Care
High Performing, Accountable and Efficient Health System
System Transformation Through Integration
LHIN Capacity to Make it Happen
Our Priorities
1 ADDRESS the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources
2 PREVENT and delay serious illness and injury among those who are at greatest risk of declining health
3 IMPROVE the patient experience
4 DELIVER value and sustainability through efficient use of resources
5 SUSTAIN our gains
Transforming the system for your health.

Strategic Priority: Address the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources.

Strategic Priority: Prevent and delay serious illness and injury among those who are at greatest risk of declining health.

We know that 1% of the population accounts for approximately one-third of health care costs. Sustainability of the health care system in the future is dependent on efficient and effective management of the resources that are available today. To ensure that we can continue to invest in high quality services we must strategically target our resources to where they will be most effective and will have the greatest impact on patient outcomes.

Many patients in this high-user group are not receiving appropriate care. TC LHIN is directing resources to the coordination and appropriateness of care, ensuring that these patients are able to access Long-Term Care, hospice care, rehabilitation or home care in a timely way. The LHIN will focus on particular groups within the 1% population on which to target efforts in the community sector.

Outside of the 1% of highest users there are patients who, with the right supports and services can often maintain their health and independence. Patients in this group tend to have multiple chronic diseases and use multiple parts of the system. These patients require ongoing primary care to help them to maintain their health and manage their conditions. Caregivers play an indispensable role in helping these individuals with their daily needs. Patient self-management programs may also improve their health and quality of life. A strong primary care system that is well integrated with community health services, acute care and other services and providers in the continuum of care is the cornerstone of our plan to improve the health and reduce the burden of illness in highly complex patients.

Health Links

Health Links is an innovative approach that brings together a network of health service providers to better and more quickly coordinate care for high-needs patients; the 5% of patients who are the most complex and use the most health care resources. All Health Links are accountable for achieving the overarching provincial objectives.

TC LHIN has been leading our local implementation of Health Links in conjunction with our health service providers. We have been focused on making three foundational care improvements, in addition to meeting the overarching Health Links' objectives:

1. Providing all complex patients with a primary care provider.

2. Providing each complex client with a coordinated care plan.

3. Ensuring complex clients see a primary care provider within seven days of being discharged from hospital.

These objectives are being realized through the identification of complex patients and clients, the subsequent development of coordinated care plans together with

patients and cross sectoral partners and the attachment of these patients to primary care.

> Through the work of TC LHIN Health Links and the Link's network of organizations, approximately 1,674 coordinated care plans have been developed to support complex patients and 2,976 patients have been connected to primary care.

Within the LHIN boundaries, there are nine Health Links. Implementation of the Health Links within the TC LHIN has been staggered into three waves, each of which has a population of focus. Wave 1, also known as the Early Adopters Health Links primary focus is on the complex elderly, Wave 2 has a preliminary focus on adults with mental health conditions and addictions, and Wave 3 focus has an initial focus on children and youth.

Each of the nine Health Links are responsible for the development of delivery models that leverage the most appropriate set of tools for reaching their population. These tools might include mobile, and/or virtual care depending on the health and social needs of the community and the available supports of the local health service providers.

To inform the LHIN's Health Link planning and implementation processes stakeholder engagement continues to be conducted and includes provider engagement meetings at the Health Link operational, executive and strategic levels. Additionally, client engagement and physician engagement is conducted within the Health Link Council and Stewardship groups. The feedback received through the Health Link governance structure and working groups is integrated into the implementation, development and monitoring of the TC LHIN Health Links' progress.

Other key deliverables from our Health Links include:

- Patients have been actively engaged in their care and feel supported and empowered in their pursuit of healthy living. North East Toronto Patients' Advisory Council won the 20 Faces of Change Award, created by the Change Foundation to honor those who have inspired positive changes in Ontario's health care system.

- Health Links have brought together not only health service providers but other sectors and organizations to address the medical and social needs for complex patients. For example, Toronto Community Housing Corporation and Toronto Emergency Services are informal partners working collaboratively for the betterment of the client.

- The Links have developed several resources and participated in test of change projects that are being considered for broader implementation within the new fiscal year. For example:

    - North East Toronto Health Link developed a coordinated care plan guidance document.
    - East Toronto Health Link has developed resources on Advance Care Planning.

- Don Valley Greenwood Health Link participated in the Emergency Medical Services Community Access Notification program.
- Mid -West Toronto Health Link leverages telemedicine to conduct interdisciplinary case conferences.

Toronto Central CCAC and Health Links

TC LHIN is working closely with the Toronto Central Community Care Access Centre (CCAC) and its community support service providers to support the development and implementation of various initiatives that are designed to benefit the work of the various Health Links. Here we highlight three examples:

I. Seniors

The Community Navigation and Access Program (CNAP) is a network of over 32 community support service agencies serving seniors across the TC LHIN that helps them maintain their independence and live at home with the supports they need. A toll-free phone number (1-877-540-6565) provides a single access point for anyone unsure of where to turn for community support services ranging from adult day programs to transportation to caregiver support to counseling.

The co-location of the CNAP hub response and the CCAC Information and Referral teams supported cross-organizational relationship building, collaboration and process improvements. To continue to build on this success, the Seniors Crisis Access Line will be co-located at CNAP/CCAC Coordinated Access Point to facilitate the integration of a coordinated access point for crisis services for seniors.

II. Mental Health and Addictions

TC LHIN was able to leverage existing resources, space, and expertise to create the Toronto Mental Health and Addictions Access Point (The Access Point) - one door for all clients in need of mental health and addictions supports and supportive housing to access needed services. The Access Point provides coordinated access to a number of these services within the large network of health service providers in Toronto through one application and intake assessment process.

This service refers individuals who are over 16 with serious mental health and/or addictions problems to the following services:

- Intensive Case Management
- Assertive Community Treatment Teams
- Supportive Housing

The Access Point is operational, has a standardized triage method and common referral criteria and is currently working to connect clients with services (as they become available). This single service access point is a more efficient and effective resource to coordinate the multiple health service providers within TC LHIN offering this type of care. It is also less cumbersome for clients in need of care and for health service providers looking to refer their patients.

In support of the Health Links, the Access Point has been working on three components; extending the scope of the Access Point to incorporate additional mental health services (such as early intervention in psychosis), developing an implementation plan to integrate the Addictions services into the Access Point, and developing recommendations regarding

the feasibility of supporting the Access Point with Resource Matching and Referral technology.

III. Coordinated Access to Specialists

In response to the LHIN's primary care strategy recommendations, the LHIN is working with its health service providers in support of the development of a directory of specialists to help increase awareness of resources and to help improve access to specialist services across the LHIN including access to urgent referrals for patients with complex care needs. This work will support a provincial initiative underway.

Investing in Community Health Care

Physiotherapy Reform and Exercise and Falls Prevention Phase II

TC LHIN is active both provincially and locally in the implementation of the Physiotherapy reform. Until August 2013 physiotherapy services were delivered by Designated Physiotherapy Clinics, in Long-Term Care homes, clinics and in patients' homes, and the funding model was a fee-for-service model billed to OHIP. On April 18, 2013, the Ministry announced reforms to the OHIP-funded physiotherapy program including a transfer of resources and accountability for most of the services to the LHINs. Patients currently receiving physiotherapy services would continue to receive services and there would be new net investments to enhance patient access across Ontario. Physiotherapy services continued to be delivered through 4 activity streams: In-Home, Long-Term Care, Clinic Based and Primary Care. We have implemented a plan to facilitate increased and/or improved coordination of physiotherapy service delivery with other services and with other sectors to ensure equitable access across the LHIN.

A new investment in Community Based Exercise and Falls Prevention was implemented in concert with this reform. We continue to work with the eight LHIN-funded community service providers to complete the implementation of expansion sites to increase access for these services within the LHIN, especially areas with identified gaps and to improve the model to meet client need.

> Exercise classes and falls preventions activities are offered at over 100 locations in the TC LHIN.

Long Term Care Capacity Plan

As the population changes and becomes more complex, long term care is under increasing pressure to change. Compared to residents in homes fifteen years ago, the current populations have much more complex health conditions and needs. The Government's long term care redevelopment strategy to replace aging infrastructure is also placing increased pressure on long term care home providers, particularly given the high cost of land within the City. As a result long term care homes are pressured to redevelop outside of the City of Toronto limits.

In light of these pressures on the sector, a well-informed capacity plan is needed to assess and make recommendations on the

size and type of long term care capacity required to serve residents today and into the future. The long term care capacity plan will examine the changing needs of long term care residents and make recommendations on the specialized services required in long term care homes to appropriately meet the care needs of residents. Given the requirement for many of the long term care homes to re-build, this presents an opportunity to build structures that best supports the care services required by the residents.

The LHIN has been working over the last year to build an awareness of this issue across the system, with the Ministry and Infrastructure Ontario. A request to participate in the development of a long term care capacity plan has been sent to the other four LHINs covering the GTA: Central, Central West, Central East, and Mississauga Halton. This request to the other GTA LHINs was sent in recognition that almost half of the residents on waiting lists for TC LHIN long-term care homes reside in other LHINs.

Resource Matching and Referral - Palliative Care Implementation

TC LHIN Resource Matching and Referral system has expanded to include palliative care more specifically, referrals for adult inpatient palliative care services. Better-quality data will now be available to enable improved planning for patient needs within this sector. This system supports effective and timely transitions to palliative care units, avoiding emergency room visits, potential hospital admissions and 'alternative level of care' days. Additionally, it improves system integration and access to timely information about referrals to palliative care beds.

Behavioural Support for Seniors Program

The Behavioural Supports for Seniors Program is a continuum of services provided in the community and long-term care home to support clients/residents with dementia, mental illness, addictions and other neurological conditions and their families.

In 2014-15, 33% more unique clients have been seen by the long-term care outreach teams and 31% more clients have been discharged from Transitional Behaviour Support Unit. This program has had more than 7000 client/resident contacts over the last year.

> Over 10,000 stakeholders including providers, caregivers and clients have been engaged through the Behavioural Support for Seniors Program.

Behavioural Support Specialists Project

The Behavioural Support Specialists Project (BSS) project focused on implementing and testing an initiative to achieve effective transitions between hospitals and Long-Term Care Homes. The aim is to provide enhanced community supports and reduce gaps throughout the continuum of care for individuals with mental health and addictions and individuals with behavioural issues including those with a dual diagnosis. This project supports the government's goals of reducing emergency wait times, inappropriate use of emergency services and alternate level of care days.

Key accomplishments in 2014-15 include:

- 76 new unique clients received service with over 222 client contacts in Long-Term Care Homes
- Prevented 55 emergency room visits from long term care homes
- Served 55 Alternate Level of Care or at-risk Alternate Level of Care patients in hospitals
- Safely transitioned 13 hospital patients to the right place of care

Health Equity

Health equity is an overarching priority for TC LHIN given the diversity of the population we serve and the diversity of health service providers. The central goal is to reduce or eliminate socially and institutionally structured health inequalities and differential outcomes so that all residents have equal opportunities for good health and well-being. To this end, TC LHIN has developed an equity framework to guide its equity work. This framework is based on the central goal of providing Excellent Care for All. There are three main components to the Health Equity work: 1) enabling and empowering organizations; 2) applying an equity lens and; 3) addressing identified barriers. Some of the activities driving this work are described below.

Equitable Access – Uninsured Services Plan

The Non-Insured funding envelope for TC LHIN totals approximately $2.25 million and is designated as a protected envelope within the Ministry-LHIN Performance Agreement. The funds are provided to Community Health Centres to provide for specialist care and diagnostic testing for those who are designated as non-insured and receiving Primary Care Services at a Community Health Centre.

The significant increase in the designated funding envelope over the last 3 years (55% increase) requires that the process for its use between health service providers be operationally efficient and that enhanced reporting be enacted to facilitate planning and engagement activities between the LHIN and the sector to ensure the best outcomes. TC LHIN is proactively working with the sector to accomplish the following:

- Implementation of a Standard Template Agreement to be utilized between hospitals and Community Health Centres for the referral of Community Health Centre clients who are non-insured for specialist and diagnostic services within hospitals.
- Consolidation of the Non-Insured Envelope - moving individual Non-Insured allocations from individual Community Health Centres (there are 16) to a single centre to maximize service provision.

To date, 11 hospitals have been approached by the Community Health Centres sector to sign the Standard Template Agreement. Seven hospitals have signed the agreement, 3 are actively in the process of discussion and a single hospital has expressed concerns regarding potential financial impacts that may require further LHIN activity in the process.

In 2014-15, the LHIN and its partners successfully consolidated the funding envelope from 16 Community Health Centres to a single "lead" organization. Access Alliance agreed to be the lead and hold the full funding envelope. Broader

communications to the Community Health Centres sector were disseminated in April 2015 to outline the plan to transfer and consolidate the funding envelope and enact enhanced reporting within the next fiscal year.

Measuring Health Equity

This project aims to identify health disparities among those utilizing the health care system. Select hospitals and Community Health Centres have volunteered to collect a standardized set of socio-demographic (equity) patient level data. Questions include: preferred language, whether born in Canada, ethnic origin, disabilities, gender, sexual orientation, income, and number of people supported by income. Patient data will be used to improve care and outcomes for vulnerable populations. Health data for example, is linked to patient socio-demographic data to identify disparities so they can be addressed. This data will also be shared with the Canadian Institute for Health Information (CIHI) so it can be accessed by a wider audience and inform further study. Key accomplishements over the last year include:

- Completed Community Health Centre pilot and rolled out standardized equity data collection to the rest of the TC LHIN Community Health Centres.

- Mount Sinai Hospital is working on a pilot to submit its equity data to CIHI. Once the sharing of data is complete, the remaining acute care hospitals will submit Emergency Department and inpatient data.

- Two equity symposiums were held this year for hospital, Community Health Centres and other stakeholders to share best practices in data collection and use of equity data: Embedding Equity into Quality Health Care (May 13, 2014) and Beyond Reporting: Using Demographic Data in Patient and Client Care (March 11, 2015).

- TC LHIN and/or its partners participated in several knowledge exchange events including, being a panelist at the Mississauga Halton LHIN Equity symposium, presenting to the Erie St Clair and Central LHIN leadership teams.

- Integrated guidelines and findings from the pediatric pilot into the data collection practices of Community Health Centres in the TC LHIN.

Aboriginal Cultural Competency Training

Health outcomes for Toronto's Indigenous community lag significantly behind those of the majority of the population. While there are a handful of Aboriginal Health Service providers, the broader health care system appropriate supports the range of health care services for the Aboriginal population. There is substantial evidence to illustrate that a lack of culturally safe or appropriate care is a barrier achieving good health outcomes. Canada's Indigenous/Aboriginal population has a unique history in Canada and many Indigenous people suffer the effects of intergenerational trauma associated with residential schools and ongoing broad systemic discrimination.

In order to ensure that all health service providers are equipped with the knowledge and skills to effectively serve this population, TC LHIN partnered with the Ontario Federation of Indigenous Friendship

Centres to develop and deliver Aboriginal Cultural Competency. This was the third year of implementation.

> Over 1000 people have now received Cultural Competency Training.

Our expectation is that improved cultural competency among health service providers will result in improved health outcomes for this population through the delivery of culturally safer care for patients. As 2015-16 is the final year of funding for this project, the OFIFC has been tasked with developing a sustainability plan for future training. The plan will be presented to the Toronto Indigenous Health Advisory Circle for their input and consideration.

Engaging Marginalized Populations

TC LHIN is constantly seeking new ways to expand and deepen our reach into our diverse communities, including Aboriginal, Francophone, and ethno-cultural neighbourhoods as well as reaching vulnerable/marginalized groups in our LHIN. The LHIN is committed to ensuring that the unique perspectives of those populations that are not often captured through traditional engagements are considered in health system design and planning.

Our intent with this work is to set the expectations and associated competencies, as well as the tools that will enable the LHIN to effectively reach these populations and engage them in health system design and planning. This is a multi-year project with future phases of work focused on adapting and disseminating tools in collaboration with health service providers and other system partners.

Francophone Forum on Immigrants' Mental Health and Addictions

To better serve Francophone immigrants, TC LHIN needs to better understand the unique issues experienced by this population and design targeted solutions. To this end, we held a forum with our health service providers to identify opportunities for improving the health outcomes of mental health and addictions clients in this francophone community. The group focused on key issues facing immigrants including the effects of stigmatization and access barriers to mental health and addictions services. Seventy-two participants attended the event. Results were shared with relevant health service providers and LHIN planners to shape the design of targeted solutions.

Integrated Health Service Plan Priority Updates

Strategic Priority: Improve the patient experience

TC LHIN aims to design health care services based on what people need and believe is most important to their health. Patient input is a key component of the projects and programs that we lead and fund. As part of work to improve the patient experience, we will make certain that we

include the voices of those in our community with the greatest needs who, all too often, are not well served or heard in the health system.

Strengthening Active Offer of French Language Services in TC LHIN

Active Offer has been shown in many other jurisdictions to be the most effective means of improving the uptake of translation services and this in turn improves service and patient outcomes. Active Offer is the practice by health service providers of actively identifying those that might benefit from language translation and offering this option. This project aims to strengthen the practice of Active Offer of French language services (FLS) by health service providers in the TC LHIN catchment area.

In 2014-15, the LHIN took several steps to promote and support the adoption of the practice of Active Offer of FLS including:

- Developed a tool to help health service providers implement the practice of Active Offer of FLS - ACTIVE (Access, Clarify, Target, Implement, Verify and Evaluate)
- Trained 54 health professionals who attended a half day education session
- Hosted a 90-minute webinar
- Developed the TC LHIN's French Language Services Plan

CLEAN Meds Community Engagement Strategy

A research team at St. Michael's Hospital is designing a study to assess the effects of providing the best and most effective medications to primary care patients for free - Carefully Selected and Easily Accessible at No Charge Medications (CLEAN Meds). TC LHIN has worked with the research team to develop an inclusive and comprehensive community engagement strategy to ensure the experiences and perspectives of vulnerable and marginalized individuals are considered in the design of the study intervention and throughout subsequent phases of work.

The strategy includes the development of a Community Guidance Panel that will co-design the study intervention and provide ongoing feedback and advice on the study design, the engagement process and the dissemination of research results to the public.

These consultations provide a great opportunity for individuals to get involved in issues that impact their communities. Study results will be communicated directly to decision makers provincially and federally and may inform pharmacare policy discussions in the future.

Francophone Cultural Competencies Project

TC LHIN is committed to improving care for the Francophone population, and last year we delivered on this commitment by increasing our health service providers' capacity to provide Francophones with culturally competent care. The need to make improvements in this area is a priority because quality of care and patient safety may be compromised when patients are not receiving health care in a language they understand.

Last year, the TC LHIN developed and implemented a new cultural competency training program to improve care for Francophone patients, caregivers and their families. Specifically, participants in training learn how to interact with Francophone clients in a culturally sensitive way. In

addition, TC LHIN translated an educational tool developed for Long-Term Care Homes staff working with residents who have HIV/AIDS. This program has been acknowledged by the Ontario French Language Services Commissioner, in his 2014-2015 Annual Report entitled "*A Voice for the Voiceless*", as a noteworthy initiative.

Integrated Health Service Plan Priority Updates

Strategic Priority: Deliver value and sustainability through efficient use of resources.

Clinical Service Planning

TC LHIN is bringing together providers from across the system to improve clinical care, and to gain efficiencies through integration and new approaches to service delivery. As highlighted earlier, we continue to drive this work forward in collaboration with the TC LHIN Clinical Efficiency/Clinical Utilization Committee.

The Clinical Evaluation/Clinical Utilization Committee is an advisory group to the TC LHIN formed to review and make recommendations to the TC LHIN regarding proposed changes to health care services in the hospital and CCAC sectors. The committee examines these changes within the context of the overall health system, Health Links, Health System Funding Reform as well as Ministry and LHIN priorities. This includes proactive planning related to Health System Funding Reform especially related to the introduction and effective implementation of Quality Based Procedures. This committee also reviews and adjudicates any major clinical program plans, changes in models of care or redesign, and make recommendations to TC LHIN using a system-wide planning approach with a focus on ensuring patients get the right care, in the right place at the right time. This initiative is on target.

Stroke, Total Joint and Hip Fracture Best Practice Implementation – Phase III

At the end of 2013/14, the TC LHIN CEO Hosptial Sector Table endorsed the reallocation of approximately $3.2M to the rehabiliation sector, predominatly from the acute care sector with some funds reallocated from CCAC. The aim was to:

- Establish outpatient rehabilitation programs for mild strokes and total joint replacements.
- Right size the inpatient rehabilitation capacity needed for these patient populations.
- Increase the intensity of multidisciplinary services in the rehabilitation beds to meet the patient needs

In 2014/15 the rehabilitation sector received the reinvestment and developed programs that aligned with the established future state model. Both acute and rehabiltiation hospitals had to adjust internal processes to maximize the impacts of the reinvestment strategy – and there was strong collaboration between health service providers to realize this potential. In 2015/16, we will enter the final stage of this project – monitoring and evaluation, to

ensure complete and consitent implementation, as well as to validate the projected benefits (quality and cost).

Congestive Heart Failure – Phase III

Congestive Heart Failure is one of the largest causes for hospital admissions – and in many cases patients could have received appropriate care in the community.

Presently there are many mild/moderate patients who present at the Emergency Department are admitted, but could avoid an admission if there was the appropriate community/ambulatory services. There are also examples of seriously acute patients that are discharged to the community who suffer poor outcomes because of the lack of support. To improve Congestive Health Failure care, a redesigned pathways for Congestive Heart Failure was implemented at two of the University Health Network 's Emergency Departments and a post-Emergency Department (ED) ambulatory clinic has been established. Over the last year, the program was evaluated and outcomes include:

- reduction of inappropriate admissions
- decrease repeat ED visits
- improved transition post ED visit
- improved patient experience
- improved links between the hospital and primary care (who are often the principal manager of these patients)

The goal is to apply the lessons learned and spread this initiative to other acute care hospitals.

Academic Health Sciences Centre - Cardiac Care Plan Phase I

TC LHIN's Academic Health Science Centres (University Health Network, Sunnybrook Health Science Centre and St Michael's Hospital) are major providers of cardiac care to local patients as well as a primary resource to the province.

Current funding does not adequately reflect current practice realities and costs of therapies including the introduction of new technologies and new life saving procedures. Significant redistribution of the program funding to other parts of the province threaten the overall viability of the cardiac programs in the TC LHIN.

In response, TC LHIN initiated an Academic Health Sciences Centre Cardiac Care planning process including representation from Sunnybrook Health Sciences Centre, University Health Network, St. Michael's Hospital, TC LHIN and the Cardiac Care Network. These organizations came together for the first time to set a common strategic direction – that included a focus on access, integration, transition to primary care, research, quality and education. Together, there is great potential to increase value for money, improve organization of care and foster innovation through their academic mission.

Integrated Orthopaedic capacity Plan Phase I

Each LHIN is creating an Orthopaedic Capacity Plan to inform the implementation of Quality based Procedures through funding reform . TC LHIN convened a Steering Committee that includes the Chairs of Orthopaedics at each of the eight acute care hospitals and the corresponding Clinical Vice Presidents to guide the work moving forward.

Community Based Rehabilitation Capacity Plan

TC LHIN is working with partners from across all sectors to initiate a plan to increase access and coordination of rehabilitation services provided in the community.

The Community Rehabilitation Planning steering committee was formed to provide strategic guidance and oversight. Membership was representative of a broad range of stakeholders from across the system including provincial level interest groups. TC LHIN was presented with final Current and Future State reports to guide future activities and investments.

- Cross-sector meetings with health service providers (15 Hospitals, 18 Community Support Services, the Community Care Access Centre and 4 Community Health Centres) were held to inform future state options.

- Select health service providers were asked to assist the committee by doing client and consumer engagemet to collect feedback and insight into the barriers of current state and options for future state.

The proposed Future State was used to guide the implementation of new 14/15 funding received by the TC LHIN including new investments of Physiotherapy in primary care and Assess & Restore funding aimed at frail seniors. This vision for the future state of rehabilitation services will continue to guide activity in fiscal 15/16.

Vision Care Planning - Phase I

Each LHIN is developing a Vision Care Plan based on a recently released provincial Vision Care Plan. To develop the plan, TC LHIN created a Task Force including the Department of Ophthalmology and Vision Sciences at the University of Toronto and partner organizations such as Kensington Eye Institute. This project was purposefully delayed until the next fiscal year because of a number of factors including the impact of the other GTA LHIN plans on TC LHIN and other key vision care projects.

Physiotherapy Reform and Exercise and Falls Prevention Phase II

I. Assess and Restore Plan Phase I

Assess and Restore interventions are short-term rehabilitative and restorative care treatments. They are meant to help seniors and other people who have experienced a reversible loss of their functional ability and who risk losing their independence. TC LHIN has received 3 years of one-time funding ($1,040,300/year) targeted to restorative care for the community dwelling frail seniors population, in support of the recently launched Assess and Restore (A&R) Guidelines. The Guidelines were developed by the Ministry in collaboration with the LHINs, health service providers and clinical experts from across the province. They outline the expectations and define the roles and responsibilities of LHINs, health service providers, and health workers in delivering Assess and Restore interventions across five areas: screening, assessment, navigation and placement, care delivery and transitions home. Over the last year, TC LHIN undertook a targeted call for year 1 of the one-time funding. The LHIN funded 7 initiatives. In early 2014, TC LHIN brought together key stakeholders to determine and facilitate year 2 and year 3 planning.

II. Implementation of Physiotherapy in Primary Care

TC LHIN is active provincially and locally in the implementation of the Physiotherapy (PT) reform. On April 18, 2013, the Ministry announced reforms to the Ontario Health Insurance Plan -funded physiotherapy program including a transfer of resources and accountability for most of the services to the LHINs. Patients currently receiving physiotherapy services would continue to receive services and there would be new net investments to enhance patient access across Ontario. In the summer of 2013, TC LHIN in collaboration with the Ministry issued a call for proposals for Physiotherapy in Primary Care. The LHIN was later notified of the funding for the successful proposals. We then brought together the funded Community Health Centres with the aim of later engaging the funded Family Health Teams to coordinate start-up implementation and evaluation of the new physiotherpy programs in primary care.

Provincial Interest Program (PIP) Reviews - Acquired Brain Injury (ABI) and Stroke

All LHINs have been asked to undertake a current state assessment of their Acquired Brain Injury (ABI) and Stroke programs. This past year, TC LHIN submitted its LHIN-specific review of Acquired Brain Injury and Stroke. In addition, the Pan-LHIN Aquired Brain Injury and Stroke report was submitted to the Ministry and includes TC LHIN information. We are waiting for the Ministry to announce the next steps.

Provincial Interest Program - Forensic Mental Health (FMH) Provincial Plan Phase I

Forensic Mental Health services are funded through global budgets of hospitals across the province. Several Forensic Mental Health programs have indicated they have both capacity and funding pressures. As per the Minsitry LHIN Performance Agreement, LHINs have a responsibility for the oversight of these hospitals and there is a need for LHINs to work with the Ministry to innovatively address funding presuress related to the significant growth in demand for services and to participate in the development of performance metrics.

- A comprehensive Forensic Mental Healthknowledge transfer session was organized by TC LHIN and presented by the Ministry.

- A Forensic Mental Health Liaison Committee was established with Terms of Reference and has met twice by videoconference.

- A Forensic Mental Health Liaison Committee made up of Ministry and LHIN representatives was organized to clarify the respective roles of the Ministry and LHINs with respect to Forensic Mental Health and to create a draft Work Plan to ensure clarity about deliverables and timelines.

- A survery was developed for the identification of issues/pressures from a provincial and local perspective and associated recommendations.

Integrated Health Service Plan Priority Updates

Strategic Priority: Sustain our gains

Our foundational work underpins programs, services and investments across multiple priorities. While these activities may not directly impact a priority, they are critical to building the capacity that is needed to carry out the strategic goals of the organization.

As an example, a key contribution that the TC LHIN is able to make, as a local planner and funder, is to create the synergistic effect of bringing system players together with a variety of tools, such as shared technology projects, planning projects, or partnerships around common priorities.

These efforts are carried out to make the system work more collaboratively by leveraging each partner's resources and unique characteristics toward common objectives that improve care. These cross-cutting initiatives serve to improve the core functions and patient outcomes.

Foundational Activities

Health System Funding Reform – TC LHIN Local Partnership Lead

The TC LHIN Health System Funding Reform Local Partnership acts as an advisory committee to the LHIN. The Local Partnership facilitates successful change management including organizing education sessions and working closely with health service providers to identify clinical and financial issues and potential consequences related to funding reform – Health Based Allocation Model and Quality Based Procedures - and to develop mitigation strategies.

There has been an increasing concentration of high needs complex clients receiving Community Care Access Centre (CCAC) services in the community. This population historically would have had longer lengths of stay in hospital or would have been admitted sooner to a long term care home. The expectation today is that this population will now receive CCAC services in the community. The question that this deliberate strategy raises is whether there are unintended consequences on Health System Funding Reform funding as a result.

TC LHIN and our Local Partnership Table worked in partnership with the Toronto Central CCAC to do a deeper analysis of the Health Based Allocation Model within the CCAC sector and it's alignment to LHIN and Ministry strategic directions in order to better understand how caring for complex patients in the community would impact Health System Funding Reform.

Key accomplishments:

- Partnered with the Ministry to provide Health System Funding Reform education sessions on 1) program implementation and 2) data quality improvement.

- Analyzed the impact of Level of Care adjustments in the Health Based Allocation Model formula to improve how tertiary/specialized care is modeled.

- Determined how to mitigate the impact of the expected variation in the Case Mix Index results on the Quality Based Procedures carve out and subsequent funding.

Emergency Preparedness

TC LHIN was chosen by the Ministry to lead a review and reinforcement of emergency preparedness within the health and community sectors inside the geography affected by the 2015 Pan Am and Parapan Am Games. Working in concert with the Central, Central East, Central West, Mississauga Halton, Hamilton Niagara Haldimand Brant and North Simcoe Muskoka LHINs, the intent has been to incorporate best practices and achieve sustainable development as a legacy of the Games.

The first key accomplishment is the creation of an Emergency Management Communications Tool. This dashboard type, internet based technology is similar to systems used around the world and will allow LHINs, hospitals, Emergency Medical Services, Public Health Units, the Ministry's Emergency Management Branch, Criticall and other partners to share information in a secure, near real-time system. This improved situational awareness will reduce dependence on lengthy teleconferences, help create a shared picture of incidents throughout an emergency, assist in documentation of actions, and promote accountability.

The second key accomplishment is the creation of a coordinated communications architecture amongst the seven LHINs hosting venues for the Games. This has allowed for timely and detailed planning to address potential stresses placed on the health and community sectors during the six weeks of the Games, and for more efficient coordination with the Ministry's Emergency Management Branch.

A series of exercises increasing the health sector's ability to deal with emergencies during the Games, and validating system readiness, has been another milestone reached this past year. This series of exercises cumulated in the federally funded Exercise CELEBRATORY SPIRIT, where TC LHIN worked with the Office of the Fire Marshall and Emergency Management to incorporate health sector scenarios into a three-day exercise involving over 1,000 players from related sectors at all three levels of government.

Finally, the community sector has received training in emergency preparedness through a series of training sessions, key leader engagements, and the creation of online resources. The LHIN has been able to assist community partners in the creation of emergency management and business continuity plans and this has better enabled these community organizations to respond to emergencies while continuing to meet the needs of their clients

eHealth

Provincial Resource Matching and Referral - Provincial Standards Sustainability Office (PSSO)

The Provincial Resource Matching & Referral (RM&R) Business Transformation Initiative was initiated several years ago to begin addressing significant challenges in Ontario's patient referral landscape such as inconsistent workflows, processes, tools, terminology, and data. This initiative

focused on developing and implementing Provincial Referral Standards for four in-scope referral pathways: Acute inpatient (medical/surgical) to CCAC, Long Term Care, Rehabilitative Care, and Complex Continuing Care.

In early 2014, the RM&R Provincial Standards Sustainability Office was established within the TC LHIN for a one year term in order to:

- Build upon foundational investments made to date.
- Monitor and evaluate ongoing implementation and use of developed Provincial Referral Standards.

- Finalize a sustainability model for beyond the 2014/15 fiscal year and to provide recommendations for future opportunities to build on this work.

Key accomplishments:

- As of March 2014, over 819 health service provider sites (72%) are currently live with Provincial Referral Standards, with many planning on completing implementation early in the next fiscal year. By 2015-2016, it is expected that all health service providers within Ontario will be using the same information to refer an acute care patient to CCACs, Long-Term Care, Rehabilitative Care and Complex Continuing Care.

- Completed the Open Access Initiative. This work included the confirmation of bed numbers and types of Rehabilitative Care and Complex Continuing Care beds across the province, LHIN identification of any current restrictions on these beds, confirmation of LHIN plans to address any existing restrictions, and the completion of a final report outlining future recommendations that was circulated to all the LHIN CEOs.

- Completed design of a Provincial Evaluation Framework and LHIN Implementation Guide to support the Provincial Evaluation of Provincial Referral Standards. This work included engagement of key stakeholders (including all 14 LHINs, the Ministry and eHealth) to confirm their role in the evaluation.

Community Business Intelligence

The Community Business Intelligence is a data collection technology, database, and reporting portal to facilitate collection of individual client level data from community mental health, addictions, and support service organizations. This data will equip both the LHIN and health service providers with the information required to make evidence-based planning and allocation decisions.

Key accomplishments:

- Out of a potential 70 organizations, 53 participated in the first upload to the Institute for Clinical Evaluative Sciences

- A universal data feed was developed and is currently being piloted in order to enable us to include data feeds from organizations who do not have compatible client management systems.

- Privacy software has been acquired to support the LHIN's querying abilities and enable the best information possible while protecting client privacy.

Community Information Management/ Community Shared Service Collaborative

In 2012, the TC LHIN developed and is now implementing a comprehensive Community Information Management Information Technology Strategy to better support service delivery and overcome the challenges of insufficient infrastructure within the community sector. The vision of this strategy centered on the need to improve health service delivery in the community by: achieving cost savings through bulk purchasing, integrating the use of information and the provision of required technology, and building community capacity and expertise related to information infrastructure.

This strategy includes three streams of work aimed at supporting community health service providers: 1) developing a Community Shared Service Collaborative Model, 2) seeking a Managed IT Services Vendor for the Community and 3) providing support for a common Client Management System.

I. A Community Shared Service Collaborative Model

This is a voluntary initiative allowing community sector health service providers to access a variety of IT services based on need. The Community Shared Services Collaborative supported the LHIN's one-time community funding process, and helped to bulk purchase hardware and equipment for 32 health service providers, with an average savings of 17%. In total, over 120 items were purchased with help from the Collaborative.

II. Seeking a Managed IT Services Vendor for the Community Sector

It is widely recognized that outsourcing IT to an IT services provider can offer organizations tremendous benefits including: spending less time managing IT, cost savings, resource efficiencies and access to a large knowledge database and reduction of IT related risks. Based on the findings from Information Management Information Technology assessments of a number of community sector organizations, the TC LHIN began to work on the foundational components of Managed Information Technology Services for the community sector.

These assessments were also used to develop requirements for a Request for Information process to seek a common managed IT services vendor for the community. Submissions are currently being reviewed and findings will be communicated through a public report to the community sector along with recommendations for next steps.

III. Support for a common Client Management System

The functionality within health service provider's current Client Management Systems is not meeting their needs and there are additional concerns related to vendor costs when reporting requirements change. The aim is to address both health service provider and LHIN concerns through the use of a common Client Management System that meets the distinct business needs of community organizations, and forms a strong foundation for standardized data collection and reporting of client-level information – an essential first step to

integration of community sector data with other health sectors.

In April 2013, a working group was formed to advise and guide the project. The working group informed the Functional Requirements and a Request for Information. Based on the Request for Information responses, it was determined by the working group that a) a single solution could support cross-sector implementation and b) a commercial-off-the-shelf solution (with some customization) could fulfill the requirements of the desired model. Following this work, a Request for Proposal for a single Client Management System was issued with vendor selection scheduled to be completed early in the new fiscal year. TC LHIN is also working with Reconnect to determine potential support and implementation models moving forward.

Integrated Decision Support (IDS)

Integrated Decision Support is a reporting tool that provides users (health service providers and the LHIN) with access to additional clinical information regarding patient journeys across disparate encounters, providers, sectors (hospital and CCAC) and geographies that previously would have taken significant effort to stitch together, quickly and accurately.

Six LHINs will be submitting information to the Integrated Decision Support system by early 15/16. Health service providers, within the circle of care, can use this system to put interventions in place to improve patient outcomes. The system will also provide the LHIN and health service providers with more timely information regarding patient experience to inform program planning.

This fiscal, the IDS team has provided new standard reports and improved data linkages enabling further analysis on cross-sector patient journeys. Health service providers are using the system to identify high-risk patients and developing strategies on how to improve care planning for these patients (e.g. potential Health Links patients). The aim is to continue to work with the Ministry to make the Integrated Decision Support system a provincial and sustainable tool.

HSP360

TC LHIN has successfully launched HSP360, a reporting portal that provides a centralized location and common view for the LHIN and health service providers to access performance information across programs (e.g. Quality, Accountability). We now have a better understanding of how an organization is performing individually and compared to their peers.

Initial feedback from multiple stakeholders including health service providers, TC LHIN staff and colleagues at other LHINs to whom the portal was introduced has been extremely positive. Key benefits identified include enhanced decision support, transparency and efficiency gained through reduced report burden on stakeholders to pull disparate data together in order to create meaningful reports.

Data Collaboration - Toronto Community Health Profiles Partnership

In partnership with the Toronto Community Health Profiles Partnership (TCHPP) the LHIN has embarked on a new data collection project to provide timely, relevant and accessible health-related data at various levels of geogrpahy for the LHIN and its health service providers. This project leveraged established relationships, expertise and existing resources to increase

access to more comprehensive, high quality and standardized web-based data and indicators. For example, users can access data pertaining to:

- Socio-demographic characteristics of neighbourhoods in Toronto
- Health service utilization
- Health outcomes
- Health equity measures

Since 2001, this project has been generating high quality health indicators, hosting workshops on how to utilize the TCHPP website for planning and maintaining a public website to allow users access to data to better inform their work.

This year, TCHPP has updated many of the indicators as new data became available, enhanced the number of comparator indicators available to TC LHIN by providing indicator results for other LHINs across the province for example, readmissions and chronic disase rates. Previously only City of Toronto comparators were available. These comparators allow TC LHIN to identify top performing LHINs and connect with them on strategies to improve performance.

6. Community Engagement

Local decision-making is the model that the LHINs are built on, and one that values the input of community members, health care professionals, and stakeholders to inform our planning and decision-making processes. The LHIN is the sole planning entity with the legislated mandate to engage the public, patients and their families regarding the design and integration of services.

Working with Providers and Community Partners

TC LHIN recognizes that every community within our borders has unique characteristics and needs and we make our best effort to consider all voices when we undertake community engagement. TC LHIN engages with six types of groups: public; health service providers; health professionals/workers; strategic partners; government and elected officials; interest groups; and priority communities.

- Quarterly Sector Table meetings bring the CEOs and Executive Directors of each sector together as a group to meet with TC LHIN and to review performance on accountability agreement targets, to problem solve and to agree on strategies to improve quality of care.

- Health Links have several mechanisms, such as the monthly Project Directors and quarterly Peer to Peer meetings, for cross link sharing of information, problem solving and design of common approaches to advance HL implementation.

- TC LHIN's three primary care physician advisors continue to work with health system and community partners including Health Links to support TC LHIN's Primary Care Strategy.

- TC LHIN's ED and Critical Care Leads work closely with clinicians on strategies to improve patient flow, ER wait times and patient access to appropriate hospital and community care.

TC LHIN's Board and the Community

Each year the Board of Directors participates in various community experiences and activities to learn about specific programs and services that are provided in the TC LHIN. The Board goes out and participates in community tours to provide them with opportunities to meet with citizens and patients in the areas where they live and work and where they receive health care services.

During the past year, for example, members of the Board toured Baycrest Hospital. The visit provided the Board of Directors with a learning opportunity about seniors care and how Baycrest is providing leadership and innovative care to patients needing behavioural support and other applicable programs and services.

The Board also receives presentations regularly from community groups and other stakeholders at their Board meetings. Topics of presentations are designed to be aligned with TC LHIN's strategic plan priorities.

Select Populations

Aboriginal Peoples

The City of Toronto has one of the largest and most diverse urban Aboriginal populations in Ontario. To respond to the needs of these communities, Toronto offers more urban Aboriginal services than any other city in Ontario. Most of these Aboriginal services are housed within Aboriginal health and social service agencies in the community; however, there are also a suite of Aboriginal specific services that are offered through mainstream organizations such as hospitals, community support services, and Public Health.

Appropriate Aboriginal health planning can be a challenge as there are a high number of services, many of which have shorter life cycles as determined by funding source. It has also been identified that a core principle for Aboriginal health planning is self-determination, meaning planning must be determined by and for the local Aboriginal community and organizations. The LHINs have a duty to consult Aboriginal peoples in the development of any service or initiative that is designed for that community. This means that in order for organizations such as the TC LHIN and Toronto Public Health to be effective in meeting the needs of the Aboriginal communities they serve, we must develop and maintain strong relationships with the Aboriginal community.

Building on its ongoing work and success in engaging with the Aboriginal community, TC LHIN received funding of $75,000 from the Ministry to enhance existing cultural competency training and collaborations in order to address cultural safety in the hospital setting. Through a collaborative partnership that includes TC LHIN and Central LHIN, the Aboriginal community and St. Michael's Hospital, an approach was identified and tested to provide cultural competency training for hospital staff. This project developed a core Aboriginal cultural competency training module and approach that is suitable in a Toronto hospital environment. For the purpose of this project

and given the short timeframe, the scope of the project focused on building hospital staff capacity to support the implementation of a dedicated Aboriginal response to opiate withdrawal in the ER.

Aboriginal cultural competency training has been delivered to over 1000 health service providers from 2012-2015 and this work will be ongoing into the coming years. A model of training that includes online as well as in person training is being developed.

Francophone Community

I. Improve Access to Culturally Competent Health Services

In collaboration with the Central West LHIN, Mississauga Halton LHIN and Reflet Salvéo, the French Language Health Planning Entity in our region, TC LHIN undertook a comprehensive LEAN-based planning process to ensure alignment with the priorities of the Ministry, the 2013-16 Integrated Health Services Plans of each of the three LHINs, Reflet Salvéo's strategic vision and the recommendations made by various sectors in previous community engagement reports. This collaborative work served the purpose of clarifying our common understanding of and identification of our priorities such as primary care access including mental health, keeping people out of institutions, and better health system navigation in French. This process informed the development of the new Joint Annual Action Plan that will guide our work over the next 3 years.

TC LHIN also worked with Reflet Salvéo and the Toronto Central CCAC's Health Care Connect team to identify unattached Francophones and connect them with a primary care provider who offers services in French to enhance access to French Language Services whenever possible. The LHIN will continue to work the Toronto Central CCAC in order to increase the number of francophone primary care physicians participating in Health Care Connect, to ensure French speaking physicians are identified through this system in a way that facilitates appropriate patient/clinician matching, and to develop a community engagement plan to promote Health Care Connect in the francophone community.

II. Improve the Capacity of Providers to Deliver French Language Services

TC LHIN, in partnership with Reflet Salvéo began creating care pathways for Francophone mental health and addictions service users with the goal of improving access and the continuum of care. The LHIN is also exploring the possibility of partnering with Entity #4 – covering the Central, Central-East and North Simcoe Muskoka LHINs – to establish coordinated care pathways that cover the entire City of Toronto.

TC LHIN was also instrumental in bringing together representatives from three Ministries – the Ministry of Health and Long-Term Care, the Ministry of Education and the Ministry of Children and Youth Services – and the Centre Francophone de Toronto in order to leverage funds from all three Ministries to create a Day Treatment Program for Francophone transitional aged youth 13 to 18 years old under the provision of Section 23 - Minority Language Educational Rights.

In 2012/13, Reflect Salvéo brought forward recommendations to the TC LHIN to address gaps in care for Francophones living with HIV/AIDS. In response, over the

last year, TC LHIN facilitated discussions with health service providers to determine how to better coordinate care for this population. We have since aligned our efforts with a larger initiative being led by the Ministry's AIDS Bureau, coordination of service now include LHIN and non-LHIN funded agencies.

Quality of care and patient safety can be compromised when health care providers do not respond to the language and cultural preferences and differences of service users. TC LHIN is committed to improving the cultural competency of health service providers serving the Francophone community. We launched a new cultural competency training program aimed at improving the care experience for Francophone patients, caregivers and their families. This program helps participants, employees and staffs across all levels of the organization to interact with Francophone service users in a more culturally sensitive way.

In 2014/15, we also offered our health service providers, educational opportunities to learn how to move towards becoming a bilingual organization as well as sessions geared to strengthening active offer of French language services.

Health Links Engagement

Health Links bring community and primary care services together in nine local communities across TC LHIN and are a driver for community transformation. The focus is to improve access to needed services and coordinate care for the most complex clients in our communities.

Health Links are committed to engaging with patients and their families, caregivers, are actively engaged in their care and feel supported and empowered in their pursuit of healthy living. Several Health Links have established Community Engagement Panels and Patient Advisory Councils to co-design resources tailored to improve the client experience and navigation of the health system. North East Toronto Health Link Patient Advisory Council, for example, created an "All About Me" card. The card captures information on communication preferences, medication, and caregiver supports. The card is currently distributed within Sunnybrook Health Sciences Centre's emergency department to patients that would benefit from a coordinated care plan.

A significant value Health Links have illustrated is the establishment of connections and collaboration between primary, tertiary and social service providers. In partnership with the Ontario Medical Association, the Central West and West Toronto Health Links held an engagement event for primary care physicians. The purpose of the engagement was to understand the needs of primary care physicians and highlight Health Links as a way to provide better coordinated and integrated care for their complex patients. Early Adopter Health Links, leverage Telemedicine Impact Plus nurses, to engage solo physicians within the community on Health Links to improve their access to an interdisciplinary case conference to support their complex patients. Don Valley Greenwood and East Toronto Health Links also held a physician engagement event on access to specialists. The event was attended by over 40 primary care providers and specialists.

Engaging Diverse Communities

TC LHIN's approach to community engagement considers the input of all community members, and in particular, diverse communities and marginalized populations, as integral to the achievement of our organizational goals. Carefully planned and executed community engagement strategies that include efforts to reach those who face barriers to participation, have the potential to shape transformative strategies for a better health care system.

With this in mind, TC LHIN has undertaken some important and targeted community engagement work in 2014/15. To support TC LHIN's strategic planning process and to respond to a request from the Expert Group on Home and Community Care (HCC), TC LHIN took a population based approach to gather community input by engaging select sub-populations within the LHIN. We chose this approach to ensure that the perspectives which are often overlooked through traditional means of engagement were considered by decision-makers and informed the development of recommendations to improve the quality, value and patient experience in HCC.

The select sub-populations were recruited through grassroots community agencies and included:

- 6 ethno-racial older adult groups (Spanish speaking, Chinese, Greek, Afghan, Bangladeshi and a diverse group from South Asia, East Africa and the Caribbean)
- Lesbian Gay Bi Transgender Queer (LGBTQ) older adults
- Francophone older adults
- Aboriginal Youth (from a caregiver perspective)

During November of 2014, TC LHIN conducted nine focus groups with these sub-populations, reaching over 250 people, Where required, community translators were used to facilitate sessions with ethno-racial groups.

In addition to the focus groups, all participants were asked to complete an optional short survey about their health and wellbeing. The survey was translated into French and Farsi; 239 surveys were submitted.

The perspectives and advice collected were analyzed to identify similarities and patterns across sub-populations and shaped into practical recommendations. These recommendations were used to inform the HCC Expert Group's recommendations to the Ministry. In addition, the insights and feedback from these sub-populations helped to shape the TC LHIN's new 2015-18 Strategic Plan.

7. Performance Results

PI No.	Performance Indicator	LHIN 2014/15 Starting Point (same as 2013/14)	LHIN 2014/15 Performance Target	Most Recent Quarter 2014/15	FY 2014/15 LHIN Result
1: Access to healthcare services					
1	90th percentile ER length of stay for admitted patients	25.73	25.00	28.82	26.60
2	90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	7.82	7.50	7.68	7.75
3	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	4.63	4.50	4.38	4.47
4	Percent of priority IV cases completed within access target (84 days) for cancer surgery	91.00%	90.00%	94.09%	94.40%
1: Access to healthcare services					
5	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	98.10%	90.00%	99.00%	99.00%
6	Percent of priority IV cases completed within access target (182 days) for cataract surgery	96.00%	90.00%	89.75%	90.09%
7	Percent of priority IV cases completed within access target (182 days) for hip replacement	90.00%	90.00%	84.44%	88.17%
8	Percent of priority IV cases completed within access target (182 days) for knee replacement	87.00%	90.00%	93.49%	94.25%
9	Percent of priority IV cases completed within access target (28 days) for MRI scans	44.00%	50.00%	28.12%	41.32%
10	Percent of priority IV cases completed within access target (28 days) for CT scans	70.00%	70.00%	56.42%	59.09%
2: Integration and coordination of care					
11	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	10.64%	10.60%	10.00%	9.63%
12	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	36.00	30.00	24.00	25.00
3: Quality and improved health outcomes					
13	Readmission within 30 Days for Selected CMGs**	18.63%	18.00%	17.56%	18.79%
14	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	26.30%	23.00%	26.44%	27.18%
15	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	37.10%	33.00%	38.40%	40.60%

*FY 2014/15 is based on most recent four quarters of data (Q4 2013/14 - Q3 2014/15) due to availability

**FY 2014/15 is based on most recent four quarters of data (Q3 2013/14 - Q2 2014/15) due to availability

Table Legend

- The LHIN result has met its target
- The LHIN result does not meet the target for this indicator but has improved from baseline
- The LHIN result does not meet the target for this indicator and has not improved from baseline

Performance Highlights

Improved Performance

More than 90% of the non-urgent cataract, cardiac, cancer and knee replacement surgical patients were seen within provincial access target timeframes with improvements noted in the 2014/15 result.

Patients are waiting less time to receive in-home services from the CCAC. The percentage of alternate level of care days has decreased, meaning that patients are being placed in more appropriate settings of care sooner.

Fairly Stable Performance

ED Length of Stay for admitted, non-admitted complex and minor patients has remained fairly stable for 2014/15. TC LHIN hospitals are undertaking a range of initiatives around emergency department efficiencies, improving patient flow and through the Pay for Results (P4R) action plans to support reducing the emergency department length of stay.

Worsened Performance

Readmissions and repeat emergency visits related to mental health and substance abuse rates continue to be a challenging indicator to improve for the LHIN. The best practice handbooks developed for congestive heart failure, chronic obstructive pulmonary disease, and pneumonia, through the Quality Best Practice work should help to improve readmission rates. Some of the other initiatives include implementing standardized discharge summaries in hospitals and community initiatives (e.g. Telehomecare).

TC LHIN has a multipronged approach to drive improvements i.e. working with MHA Acute care alliance and community partners, Health links focussed on complex mental health population and longer term impacts realized through system transformation activities.

8. Looking Ahead

As the TC LHIN evolves as an organization, so does our approach to planning. We are now taking a population health approach to improving the health of our City. This will involve working with our providers to continue building a world class health care system that will benefit all those receiving health care.

TC LHIN's new 2015-18 Strategic Plan will guide our work over the next four years and includes strategies to divide the population into sub-groups (or sub-populations) so that we can better reach and more effectively serve all those who may need care. By moving to a population health approach to planning, we will be better positioned to fulfill our core commitment of serving everyone and serving them well.

As we seek to broaden our reach across and within communities, we will work to ensure that the individual experience of each patient is as seamless, respectful, and meaningful as possible. Our efforts will focus on ensuring that system design and service delivery are responsive to the needs of patients and their families, and grounded

in and informed by their perspectives. We will also prioritize timely access to quality care in the community, as close to home as is appropriate.

Without losing sight of Ontario's current fiscal reality, we are committed to making disciplined and purposeful decisions about our health investments. By making forward thinking investments and aligning funding to outcomes, we will work to ensure that the communities we serve can count on us to meet their health needs, even as they evolve over time.

Our new strategic plan will be guided by three overarching goals:

1. A Healthier Toronto
2. Positive Patient Experiences
3. System Sustainability

We have also adopted four strategic priorities that will guide our investments and activities to drive the reforms needed to achieve our goals:

1. Designing Health Care for the Future
2. Taking a Population Health Approach
3. Transforming Primary and Community Care
4. Delivering Excellence in Operations

These goals and strategic priorities will be front of mind over the next four years, as we continue to work in close collaboration with our local health service providers and the communities we serve.

9. Toronto Central LHIN Board of Directors

Name	Position	Appointed	End of Current Term	Length of Term
Angela Ferrante	Chair	November 3, 2010 November 3, 2013	November 2, 2013 November 2, 2016	3 years 3 years
John Fraser	Vice Chair	June 27, 2011 June 27, 2014	June 26, 2014 June 26, 2017	3 years 3 years
Carol Perry	Director	June 2, 2011 June 2, 1014	June 1, 2014 June 1, 2017	3 years 3 years
Cynthia Pay	Director	December 21, 2012	December 20, 2015	3 years
Maurice Hudon	Director	April 10, 2013	April 9, 2016	3 years
Yasmin Meralli	Director	September 8, 2014	September 7, 2017	3 years
Christopher Hoffmann	Director	October 22, 2014	October 21, 2017	
Felix Wu	Director	October 22, 2014	October 21, 2017	
One vacancy				

10. 2014/15 Audited Financial Statements

Financial statements of

Toronto Central Local Health Integration Network

March 31, 2015

Toronto Central Local Health Integration Network

March 31, 2015

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Deloitte.

Deloitte LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
Toronto Central Local Health Integration Network

We have audited the accompanying financial statements of the Toronto Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2015, and the statements of operations, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2015, and the results of its operations, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
June 24, 2015

Toronto Central Local Health Integration Network

Statement of financial position
as at March 31, 2015

	2015	2014
	$	$
Financial assets		
Cash	**1,011,834**	1,320,686
Due from Local Health Integration Networks ("LHINs")	**132,107**	20,687
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding HSP transfer payments	**34,279,012**	40,825,415
Harmonized Sales Tax receivable	**453,182**	566,371
	35,876,135	42,733,159
Liabilities		
Accounts payable and accrued liabilities	**1,666,185**	1,969,287
Due to HSPs	**34,279,012**	40,825,415
Due to MOHLTC (Note 4b)	**2,807**	13,607
Deferred capital contributions (Note 5)	**2,213,523**	2,503,058
	38,161,527	45,311,367
Net debt	**(2,285,392)**	(2,578,208)
Commitments (Note 15)		
Non-financial assets		
Prepaid expenses	**71,869**	75,150
Tangible capital assets (Note 6)	**2,213,523**	2,503,058
	2,285,392	2,578,208
Accumulated surplus	**-**	-

Approved by the Board

Angela Tumarato
Director

Director

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

Statement of operations
year ended March 31, 2015

	Budget (Note 7)	2015 Actual	2014 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care ("MOHLTC") funding	5,535,121	5,256,532	5,181,549
Ministry of Health and Long-Term Care ("MOHLTC") funding to LHINC	670,000	670,000	670,000
MOHLTC Funding to LHIN Shared Services Offices ("LSSO")	-	-	740,000
Health Service Provider ("HSP") transfer payments (Note 8)	4,621,561,004	4,761,002,833	4,715,109,989
Project Initiatives (Note 9)			
Enabling Technologies (Note 3)	580,000	510,000	580,000
Emergency Department ("ED") Lead	75,000	75,000	75,000
Aboriginal Health Transition Planning	20,000	20,000	20,000
Emergency Room and Alternate Level of Care ("ER/ALC")	100,000	100,000	100,000
Critical Care ("CC") Lead	75,000	75,000	75,000
Resources Matching Referrals Leads	206,722	370,000	626,000
French Language Health Services ("FLHS")	106,000	106,000	106,000
French Planning Entities	568,713	568,713	568,713
Primary Care Lead	75,000	75,000	75,000
Diabetes Regional Coordination Centre	1,129,301	1,129,301	1,267,521
Diabetes Early Detection	-	-	50,000
Physiotherapy Reform	-	-	27,341
Pan and Parapan Am Games	414,498	414,498	69,083
Emergency Management Communication Tool ("EMCT")	-	800,000	-
Amortization of deferred capital contributions (Note 5)	-	1,379,579	871,994
Amounts recovered/recoverable from the LHINs to LHINC	816,250	662,071	701,849
Amounts recovered/recoverable from the LHINs to LSSO	5,663,296	4,382,157	3,807,011
	4,637,595,905	4,777,596,684	4,730,722,050
Funding repayable to the MOHLTC related to operations (Note 4a)	-	(2,807)	(13,607)
	4,637,595,905	4,777,593,877	4,730,708,443
Expenses			
Transfer payments to HSPs (Note 8)	4,621,561,004	4,761,002,833	4,715,109,989
General and administrative (Note 10)	5,535,121	5,458,067	5,512,605
LHIN Shared Services Office (Note 11)	5,663,296	5,422,165	5,015,229
LHIN Collaborative (Note 12)	1,486,250	1,467,300	1,430,962
Project Initiatives (Note 9)			
Enabling Technologies	580,000	510,000	580,000
Emergency Department ("ED") Lead	75,000	75,000	75,000
Aboriginal Health Transition Planning	20,000	20,000	20,000
Emergency Room and Alternate Level of Care ("ER/ALC")	100,000	100,000	100,000
Critical Care ("CC") Lead	75,000	75,000	75,000
Resources Matching Referrals Leads	206,722	370,000	626,000
French Language Health Services ("FLHS")	106,000	106,000	106,000
French Planning Entities	568,713	568,713	568,713
Primary Care Lead	75,000	75,000	75,000
Diabetes Regional Coordination Centre	1,129,301	1,129,301	1,267,521
Diabetes Early Detection	-	-	50,000
Physiotherapy Reform	-	-	27,341
Pan and Parapan Am Games	414,498	414,498	69,083
Emergency Management Communication Tool ("EMCT")	-	800,000	-
	4,637,595,905	4,777,593,877	4,730,708,443
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

Statement of change in net debt
year ended March 31, 2015

	2015	2014
	$	$
Annual surplus	-	-
Acquisition of tangible capital assets	**(1,090,044)**	(1,573,528)
Amortization of tangible capital assets	**1,379,579**	871,994
Acquisition of prepaid expenses	**(71,869)**	(75,150)
Use of prepaid expenses	**75,150**	69,067
Decrease (Increase) in net debt	**292,816**	(707,617)
Net debt, beginning of year	**(2,578,208)**	(1,870,591)
Net debt, end of year	**(2,285,392)**	(2,578,208)

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

Statement of cash flows
year ended March 31, 2015

	2015	2014
	$	$
Operating transactions		
Annual surplus	-	-
Less: items not affecting cash		
Amortization of tangible capital assets	1,379,579	871,994
Amortization of deferred capital contributions (Note 5)	(1,379,579)	(871,994)
	-	-
Changes in non-cash operating items		
Due from LHINs	(111,420)	21,543
Harmonized Sales Tax receivable	113,189	(123,405)
Due from MOHLTC regarding		
HSP transfer payments	6,546,403	(10,678,369)
Accounts payable and accrued liabilities	(303,102)	253,696
Due to HSPs	(6,546,403)	10,678,369
Due to MOHLTC	(10,800)	(132,209)
Prepaid expenses	3,281	(6,083)
	(308,852)	13,542
Capital transaction		
Acquisition of tangible capital assets	(1,090,044)	(1,573,528)
Financing transaction		
Increase in deferred capital contributions (Note 5)	1,090,044	1,573,528
Net change in cash	(308,852)	13,542
Cash, beginning of year	1,320,686	1,307,144
Cash, end of year	1,011,834	1,320,686

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2015

1. Description of business

The Toronto Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Toronto Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the City of Toronto. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"). These financial statements reflect the terms of the MLPA related to this funding.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2015.

The LHIN financial statements do not include any MOHLTC managed programs.

The LHIN is also funded for the Diabetes Regional Coordination Centre ("RCC") program in accordance with the Ministry-LHIN Performance Agreement. The operational mandate, functions and funding for delivery of the RCC Program were transferred to the LHIN in the 2012/13 fiscal year.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are initially recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of operations, is in accordance with the amortization policy applied to the related capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year.

Segmented financial reporting

The financial statements of the LHIN include the accounts of the LHIN Shared Services Office (the "LSSO") and LHIN Collaborative (the "LHINC") which are its divisions. Separate schedules of LSSO and LHINC financial position and financial activities are presented in the attached schedules to the financial statements.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at year end are recorded as a receivable (payable) to (from) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LHINC is responsible for providing advice to all LHINs in the areas of planning integration and community engagement, allocation methodologies, accountability performance and system alignment and co-ordination. Any portion of the LHINC operating costs overpaid (or not paid) by the LHIN at the year-end are recorded as a receivable (payable) to (from) the LHINC. This is all done pursuant to the LHINC Agreement the LHINC has with all the LHINs.

Enabling Technologies for Integrated Project Management Office

Effective April 1, 2013, the LHIN entered into an agreement with the Central, Central West, Central East, Mississauga Halton and North Simcoe Muskoka LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received MOHLTC funding through the Central West LHIN of $510,000 (2014 - $580,000).

4. Funding repayable to the MOHLTC

In accordance with the MLPA and the Transfer Payment Agreement ("TPA"), the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to the current activities is made up of the following components:

	Funding received	Eligible expenses	2015 Excess funding	2014 Excess funding
	$	$	$	$
Transfer payments to HSPs	4,761,002,833	4,761,002,833	-	-
LHIN operations	5,460,874	5,458,067	2,807	2,060
LHINC	670,000	670,000	-	11,547
E-Health	510,000	510,000	-	-
ED Lead	75,000	75,000	-	-
Aboriginal Health Transition Planning	20,000	20,000	-	-
ER/ALC	100,000	100,000	-	-
Critical Care Lead	75,000	75,000	-	-
ALC Resources Matching	370,000	370,000	-	-
FLHS	106,000	106,000	-	-
French Planning Entities	568,713	568,713	-	-
Primary Care lead	75,000	75,000	-	-
Diabetes RCC	1,129,301	1,129,301	-	-
Pan and Parapan Am Games	414,498	414,498	-	-
EMCT	800,000	800,000	-	-
	4,771,377,219	4,771,374,412	2,807	13,607

During the year, the LHIN was provided net funding of $568,713 (Note 9) (2014 - $568,713) from the MOHLTC for the French Planning Entities and an amount of $568,713 was flowed directly to "Entité de planification pour les services de santé en français de Toronto Centre".

b) The amount due to the MOHLTC related to current activities at March 31 is made up as follows:

	2015	2014
	$	$
Due to MOHLTC, beginning of year	(13,607)	(145,816)
MOHLTC payment	13,607	145,816
Funding repayable to the MOHLTC related to current year activities (Note 4a)	(2,807)	(13,607)
Due to MOHLTC, end of year	(2,807)	(13,607)

5. Deferred capital contributions

	2015	2014
	$	$
Balance, beginning of year	2,503,058	1,801,524
Capital contributions received during the year	1,090,044	1,573,528
Amortization for the year	(1,379,579)	(871,994)
Balance, end of year	2,213,523	2,503,058

6. Tangible capital assets

			2015	2014
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	560,463	389,197	171,266	218,667
Computer equipment	6,204,337	4,332,001	1,872,336	1,750,354
Leasehold improvements	2,032,454	1,862,533	169,921	534,037
	8,797,254	6,583,731	2,213,523	2,503,058

7. Budget figures

The budget figures reported in the Statement of operations reflect the initial budget at April 1, 2014. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $4,761,002,833 is made up of the following:

	$
Initial HSP Funding budget	4,621,561,004
Adjustment due to announcements made during the year	139,441,829
Total HSP Funding	4,761,002,833

The total operating budget, excluding HSP Funding is $8,885,355.

8. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $4,761,002,833 (2014 - $4,715,109,989) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2015 as follows:

	2015	2014
	$	$
Operation of hospitals	**3,584,903,808**	3,581,113,829
Long-term care homes	**267,424,716**	262,005,072
Community care access centre	**244,702,630**	232,956,277
Community support services	**93,459,523**	84,357,083
Assisted living services in supportive housing	**53,669,470**	49,625,351
Community health centres	**91,699,161**	92,931,485
Community mental health addictions program	**127,118,591**	118,555,888
Addictions program	**37,861,791**	34,698,561
Specialty psychiatric hospital	**260,163,143**	258,866,443
	4,761,002,833	4,715,109,989

9. Operations of LHIN - Project Initiatives

The LHIN received funds for various initiatives listed in the Statement of operations. The following table classifies the initiatives expenses by object:

	2015	2014
	$	$
Salaries and benefits	**3,102,353**	2,114,494
Professional services	**197,164**	250,580
Funding transferred	**568,713**	568,713
Other	**375,282**	705,871
	4,243,512	3,639,658

Diabetes Regional Coordination Centre operational expenses included in the project fund expenses above are as follows:

	Actual 2015	Actual 2014
	$	$
Salaries and benefits	**954,043**	919,048
Others	**175,258**	348,473
	1,129,301	1,267,521

10. General and administrative expenses

The Statement of operations presents the expenses by function; the following classifies general and administrative expenses:

	2015	2014
	$	$
Salaries and benefits	3,954,564	3,878,810
Occupancy	263,686	259,113
Amortization	204,342	333,116
Shared services	317,718	371,494
LHINC	50,929	47,500
Consulting services	77,246	192,167
Translation services	55,390	19,250
Professional services	15,900	12,560
Supplies	48,865	25,753
Computer expenses	144,955	40,172
Governance	39,346	57,679
Mail, courier and telecommunications	42,131	102,326
Other	242,995	172,665
	5,458,067	5,512,605

The following lists the Board Chair and Directors per diem costs as well as their travel and development expenses, which are included in governance expense in the general and administrative expenses above.

		2015	2014
	Budget	Actual	Actual
	$	$	$
Board Chair per diem cost	36,408	15,050	21,000
Directors per diem cost	61,677	23,950	35,575
Board travel and development expenses	1,915	346	1,104
	100,000	39,346	57,679

11. LHIN Shared Services Office

The following presents the financial position and financial activities, by object, of the LHIN Shared Services Office (LSSO) for the year:

LHIN Shared Services Office
Statement of financial position
as at March 31, 2015

	2015	2014
	$	$
Financial assets		
Cash	**326,821**	340,350
Due from LHINs	**132,107**	20,687
Due from LHINC*	**-**	36,674
Harmonized Sales Tax receivable	**235,921**	416,649
	694,849	814,360
Liabilities		
Accounts payable and accrued liabilities	**649,741**	978,647
Due to TC LHIN*	**96,153**	(98,715)
Deferred capital contributions	**1,401,857**	1,630,410
	2,147,751	2,510,342
Net debt	**1,452,902**	1,695,982
Non-financial assets		
Prepaid expenses	**51,045**	65,572
Tangible capital assets	**1,401,857**	1,630,410
	1,452,902	1,695,982
Accumulated surplus	**-**	-

*Amounts due to/from TC LHIN and LHINC are eliminated upon combination.

11. LHIN Shared Services Office (continued)

LHIN Shared Services Office
Statement of financial activities
year ended March 31, 2015

	Budget	2015 Actual	2014 Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	5,663,296	4,783,818	4,505,758
MOHLTC funding	-	-	740,000
Amortization of deferred capital contributions	-	1,040,008	468,218
	5,663,296	5,823,826	5,713,976
Expenses**			
Salaries	1,878,077	1,603,744	1,430,609
Benefits	206,568	299,551	184,322
Supplies	40,283	29,164	27,632
Telecommunications	24,180	11,357	4,531
Recruitment and staff development	5,840	20,040	6,845
Computer expense	357,706	463,862	596,139
Consulting fees	15,000	21,244	9,035
Professional services	21,500	21,970	19,500
Meeting expenses	7,479	1,582	15
Amortization	-	1,040,008	468,218
Occupancy	181,185	167,812	167,750
Other	33,600	20,530	18,790
Outsourcing services	2,891,878	2,122,962	2,780,590
Total common LHIN services expenses	5,663,296	5,823,826	5,713,976
Less: inter-entity transactions eliminated on combination***	-	(401,661)	(698,747)
	5,663,296	5,422,165	5,015,229

** Included in total expenses above are $750,151 related to legal department expenses, of which $637,313 are salaries and benefits expenses.

*** Included in total expenses above are $401,661 (2014 - $698,747) related to inter-entity transactions and are eliminated upon combination.

12. LHIN Collaborative

The following presents the financial position and financial activities, by object, of the LHIN Collaborative (LHINC) for the year:

LHIN Collaborative
Statement of financial position
as at March 31, 2015

	2015	2014
	$	$
Financial assets		
Cash	**188,446**	188,068
Harmonized Sales Tax receivable	**1,055**	9,597
	189,501	197,665
Liabilities		
Accounts payable and accrued liabilities	**46,229**	150,320
Due to TC LHIN*	**149,596**	36,674
Deferred capital contributions	**67,614**	202,843
Due to MOHLTC (Note 4a)	**-**	11,547
	263,439	401,384
Net debt	**73,938**	203,719
Non-financial assets		
Prepaid expenses	**6,324**	876
Tangible capital assets	**67,614**	202,843
	73,938	203,719
Accumulated surplus	**-**	-

* Amounts due from the LSSO and due to TC LHIN are eliminated upon combination.

12. LHIN Collaborative (continued)

LHIN Collaborative
Statement of financial activities
year ended March 31, 2015

	Budget	2015 Actual	2014 Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	816,250	713,000	749,349
MOHLTC funding	670,000	670,000	670,000
Amortization of deferred capital contributions	-	135,229	70,660
	1,486,250	1,518,229	1,490,009
Funding repayable to the MOHLTC related to operations	-	-	(11,547)
	1,486,250	1,518,229	1,478,462
Expenses**			
Salaries	1,006,060	984,087	936,208
Benefits	204,590	197,613	210,169
Supplies	18,844	5,292	6,074
Telecommunications	11,100	8,589	1,090
Recruitment and staff developments	20,522	5,231	5,318
Computer expense	8,200	3,696	13,448
Consulting fees	35,500	8,871	68,873
Meeting expenses	13,900	7,547	9,941
Amortization	-	135,229	70,660
Occupancy	102,600	111,454	99,454
Other	20,534	6,220	9,727
Shared services	44,400	44,400	47,500
	1,486,250	1,518,229	1,478,462
Less: inter-entity transactions eliminated on combination	-	(50,929)	(47,500)
	-	1,467,300	1,430,962

**Included in total expenses above are $50,929 (2014 - $47,500) in inter-entity transactions that are eliminated upon combination.

MOHLTC funding of $30,000 (2014 - $30,000) was attributed to the Provincial End-of-Life Network, of which $11,547 was used toward the repayment of funding to the MOHLTC (Note 4a).

13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 70 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2015 was $616,320 (2014 - $520,651) for current service costs and is included as an expense in the Statement of operations. The last actuarial valuation was completed for the plan as of December 31, 2014. At that time, the plan was fully funded.

14. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the Financial Administration Act.

15. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due over the next years are as follows:

	$
2016	445,720
2017	500
	446,220

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2015 and 2016. The actual amounts, which will ultimately be paid, are contingent upon actual LHIN funding received from the MOHLTC.

Toronto Central Local Health Integration Network

Combined statement of financial position and operations by division - Schedule 1
as at March 31, 2015

Combined statement of financial position and operations by division - Schedule 1	2015	2014	2015	2014	2015	2014	2015	2014
	Toronto Central		Shared Services Office		Collaborative		Total	Total
	$	$	$	$	$	$	$	$
Financial assets								
Cash	**496,567**	792,268	**326,821**	340,350	**188,446**	188,068	**1,011,834**	1,320,686
Due from LSSO/LHINC/TC LHIN*	**245,749**	-	-	135,389	-	-	**245,749**	135,389
Due from Local Health Integration Networks ("LHINs")	-	-	**132,107**	20,687	-	-	**132,107**	20,687
Due from MOHLTC regarding HSP transfer payments	**34,279,012**	40,825,415	-	-	-	-	**34,279,012**	40,825,415
Harmonized Sales Tax receivable	**216,206**	140,125	**235,921**	416,649	**1,055**	9,597	**453,182**	566,371
	35,237,534	41,757,808	**694,849**	913,075	**189,501**	197,665	**36,121,884**	42,868,548
Liabilities								
Accounts payable and accrued liabilities	**970,215**	840,320	**649,741**	978,647	**46,229**	150,320	**1,666,185**	1,969,287
Due to LSSO/LHINC/TC LHIN*	-	98,715	**96,153**	-	**149,596**	36,674	**245,749**	135,389
Due to HSPs	**34,279,012**	40,825,415	-	-	-	-	**34,279,012**	40,825,415
Deferred capital contributions	**744,052**	669,805	**1,401,857**	1,630,410	**67,614**	202,843	**2,213,523**	2,503,058
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**2,807**	2,060	-	-	-	11,547	**2,807**	13,607
	35,996,086	42,436,315	**2,147,751**	2,609,057	**263,439**	401,384	**38,407,276**	45,446,756
Net debt	**758,552**	678,507	**1,452,902**	1,695,982	**73,938**	203,719	**2,285,392**	2,578,208
Non-financial assets								
Prepaid expenses	**14,500**	8,702	**51,045**	65,572	**6,324**	876	**71,869**	75,150
Tangible capital assets	**744,052**	669,805	**1,401,857**	1,630,410	**67,614**	202,843	**2,213,523**	2,503,058
	758,552	678,507	**1,452,902**	1,695,982	**73,938**	203,719	**2,285,392**	2,578,208
Accumulated surplus	-	-	-	-	-	-	-	-

* Amounts due from/to the LHIN Shared Services Office, due from/to the LHINC and due from/to TC LHIN are eliminated upon combination.

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

Combined statement of financial position and operations by division - Schedule I (continued)
year ended March 31, 2015

Combined statement of financial position and operations by division - Schedule I (continued)	Toronto Central Operations			Shared Services Office			Collaborative				
	2015	2015	2014	2015	2015	2014	2015	2015	2014	2015	2014
	Budget	Actual	Actual	Budget	Actual	Actual	Budget	Actual	Actual	Total	Total
	$	$	$	$	$	$	$	$	$	$	$
Revenue											
Amounts recovered/recoverable from the LHINs	-	-	-	5,663,296	4,783,818	4,505,758	816,250	713,000	749,349	5,496,818	5,255,107
MOHLTC funding	5,535,121	5,256,532	5,181,549	-	-	740,000	670,000	670,000	670,000	5,926,532	6,591,549
HSP transfer payments (Note 8)	4,621,561,004	4,761,002,833	4,715,109,989	-	-	-	-	-	-	4,761,002,833	4,715,109,989
Enabling Technologies funding (Note 3)	580,000	510,000	580,000	-	-	-	-	-	-	510,000	580,000
Emergency Department ("ED") Leads (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Aboriginal Health Transition Planning (Note 9)	20,000	20,000	20,000	-	-	-	-	-	-	20,000	20,000
Emergency Room and Alternate Level of Care (ER/ALC) (Note 9)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care ("CC") Lead (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Resources Matching Referrals (Note 9)	206,722	370,000	626,000	-	-	-	-	-	-	370,000	626,000
French Language Health Services (Note 9)	106,000	106,000	106,000	-	-	-	-	-	-	106,000	106,000
French Planning Entities (Note 9)	568,713	568,713	568,713	-	-	-	-	-	-	568,713	568,713
Primary Care Lead (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Diabetes Regional Coordination Centre (Note 9)	1,129,301	1,129,301	1,267,521	-	-	-	-	-	-	1,129,301	1,267,521
Diabetes Early Detection (Note 9)	-	-	50,000	-	-	-	-	-	-	-	50,000
Physiotherapy Reform (Note 9)	-	-	27,341	-	-	-	-	-	-	-	27,341
Pan and Parapan Am Games (Note 9)	414,498	414,498	69,083	-	-	-	-	-	-	414,498	69,083
Emergency Mgmt Comm Tool (Note 9)	-	800,000	-	-	-	-	-	-	-	800,000	-
Amortization of deferred capital contributions (Note 5)	-	204,342	333,116	-	1,040,008	468,218	-	135,229	70,660	1,379,579	871,994
	4,630,446,359	4,770,707,219	4,724,264,312	5,663,296	5,823,826	5,713,976	1,486,250	1,518,229	1,490,009	4,778,049,274	4,731,468,297
Funding surplus repayable to the MOHLTC related to operations (Note 4(a))	-	(2,807)	(2,060)	-	-	-	-	-	(11,547)	(2,807)	(13,607)
	4,630,446,359	4,770,704,412	4,724,262,252	5,663,296	5,823,826	5,713,976	1,486,250	1,518,229	1,478,462	4,778,046,467	4,731,454,690
Expenses											
General and administrative (Note 10)	5,535,121	5,458,067	5,512,605	-	-	-	-	-	-	5,458,067	5,512,605
Common LHIN Services* (Note 11)	-	-	-	5,663,296	5,823,826	5,713,976	-	-	-	5,823,826	5,713,976
LHIN Collaborative** (Note 12)	-	-	-	-	-	-	1,486,250	1,518,229	1,478,462	1,518,229	1,478,462
Transfer payments to HSPs (Note 8)	4,621,561,004	4,761,002,833	4,715,109,989	-	-	-	-	-	-	4,761,002,833	4,715,109,989
Enabling Technologies (Note 3)	580,000	510,000	580,000	-	-	-	-	-	-	510,000	580,000
Emergency Department ("ED") Leads (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Aboriginal Health Transition Planning (Note 9)	20,000	20,000	20,000	-	-	-	-	-	-	20,000	20,000
Emergency Room and Alternate Level of Care (ER/ALC) (Note 9)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care ("CC") Lead (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Resources Matching Referrals (Note 9)	206,722	370,000	626,000	-	-	-	-	-	-	370,000	626,000
French Language Health Services (Note 9)	106,000	106,000	106,000	-	-	-	-	-	-	106,000	106,000
French Planning Entities (Note 9)	568,713	568,713	568,713	-	-	-	-	-	-	568,713	568,713
Primary Care Lead (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Diabetes Regional Coordination Centre (Note 9)	1,129,301	1,129,301	1,267,521	-	-	-	-	-	-	1,129,301	1,267,521
Diabetes Early Detection (Note 9)	-	-	50,000	-	-	-	-	-	-	-	50,000
Physiotherapy Reform (Note 9)	-	-	27,341	-	-	-	-	-	-	-	27,341
Pan and Parapan Am Games (Note 9)	414,498	414,498	69,083	-	-	-	-	-	-	414,498	69,083
Emergency Mgmt Comm Tool (Note 9)	-	800,000	-	-	-	-	-	-	-	800,000	-
	4,630,446,359	4,770,704,412	4,724,262,252	5,663,296	5,823,826	5,713,976	1,486,250	1,518,229	1,478,462	4,778,046,467	4,731,454,690
Annual surplus and accumulated surplus, end of year	-	-	-	-	-	-	-	-	-	-	-

* These amounts will be adjusted by $401,661 for Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs (Note 11).
** These amounts will be adjusted by $50,929 for Toronto Central LHIN transactions. These numbers reflect LHINC operations on behalf of all 14 LHINs (Note 12).

The accompanying notes to the financial statements are an integral part of these financial statements.

11. Endnotes

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10. Environics Institute. *Urban Aboriginal Peoples Report*, 2010. ISBN 978-0-9866104-0-0. Available from: http://www.uaps.ca/wp-content/uploads/2010/03/UAPS-Main-Report_Dec.pdf
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Please note the immigration statistics are for the whole City of Toronto and are taken from the National Household Survey which has data limitations.

Toronto Central **LHIN**

ISSN 1911-3641 (Print) Annual Report (Toronto Central Local Health Integration Network)

ISSN 1911-365X (Online) Annual Report (Toronto Central Local Health Integration Network)

ISSN 1911-3668 (Imprimé) Rapport annuel (Réseau local d'intégration des services de santé du Centre-Toronto)

ISSN 1911-3676 (En ligne) Rapport annuel (Réseau local d'intégration des services de santé du Centre-Toronto)

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